The All-Payer Claims Database

Health Care Claims Data Release - Documentation Guide

APCD Preliminary Release 1

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Deval L. Patrick, Governor
Commonwealth of Massachusetts

JudyAnn Bigby, Secretary
Executive Office of Health and Human Services

Timothy P. Murray
Lieutenant Governor

Áron Boros, Commissioner
Division of Health Care Finance and Policy

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INTRODUCTION

This document is provided as a manual to accompany the release of data from the Massachusetts **All-Payer Claims Database** (**APCD**).

The **APCD** is comprised of **medical**, **pharmacy**, and **dental claims**, and information from the **member eligibility**, **provider**, and **product** files, as collected from health insurance payers for residents of the State of Massachusetts. This information encompasses fully-insured and self-insured data. **Medicare and Medicaid data are not included in the current release**. The APCD affords a deeper understanding of the Massachusetts health care delivery system by providing access to timely and accurate data essential to improving quality, reducing costs, and promoting transparency.

The application and rules governing the **purchase of APCD Data** is found on the APCD website.

The **APCD** data collection and data release are governed by the following **regulations** which are available on the APCD website:

114.5 CMR 21.00 – Health Care Claims Submission

> **114.5 CMR 21.00** governs the reporting requirements for **Health Care Payers** to submit data and information to the **Division of Health Care Finance and Policy* (Division)** in accordance with M.G.L. c. 118G, § 6. The regulation establishes the data submission requirements for **health care payers** to submit information concerning the costs and utilization of health care in Massachusetts. The Division collects data essential for the Division to monitor health care cost trends, minimize the duplication of data submissions by payers to state entities, and to promote administrative simplification among state entities in Massachusetts.
>
> Health care data and information submitted by Health Care Payers to the Division is not a public record. No public disclosure of any health plan information or data shall be made unless specifically authorized under 114.5 CMR 21.00 or 114.5 CMR 22.00.

114.5 CMR 22.00 – Health Care Claims Data Release

> **114.5 CMR 22.00** governs the disclosure of health plan information and claims data submitted by health care payers pursuant to 114.5 CMR 21.00. The purpose of 114.5 CMR 22.00 is to make health plan information and data available as a resource where such access serves the public interest while safeguarding the privacy rights of claims data subjects. Pursuant to M.G.L. c. 118G, §6, data submitted by health care payers are not a public record, and no public disclosure of any data and information shall be made except in accordance with the provisions of 114.5 CMR 22.00.

The full text of these **Regulations** can be found on the APCD website, in addition to the **Submission Guides** and **Administrative Bulletins** referred to in the Regulations which provide additional detail and amendments to requirements.

APCD Data Collection Regulation

The following description of the **APCD** is an excerpt from regulation **114.5 CMR 21.00:**

(1) General. Payers shall submit health plan information to the Division in accordance with 114.5 CMR 21.03(2) and Health Care Claims Data in accordance with 114.5 CMR 21.03(3).

(2) Health Plan Information

> Private Health Care Payers. All Private Health Care Payers shall provide data and information for all plan types, including self-insured plans, including but not limited to the following:

(3) Health Care Claims Data.

> (a) General.

*** Effective November 5th, 2012 the Division will be known as the Center for Health Information and Analysis ("Center").**

1. Submission Guide. The Division will issue a Submission Guide to specify the filing requirements and data specifications for Payers to submit Medical Claims, Pharmacy Claims, Dental Claims, Member Eligibility Files, Provider Files, and Product Files.

2. Payer Filing Requirements. Private Health Care Payers must file data in accordance with 114.5 CMR 21.03(3) and the Submission Guide. Public Payers and the Commonwealth Health Insurance Connector may provide or authorize the provision of claims data to the Division pursuant to an interagency service agreement.

3. Required Data. Health Care Payers must provide claims-line detail for all health care services provided to Massachusetts residents, whether or not the health care was provided within Massachusetts. Such data shall include but is not limited to fully-insured and self-funded accounts and all commercial medical products for all individuals and all group sizes.

4. Administrative Bulletin. The Division may amend the filing requirements and data specifications, including filing deadlines, by Administrative Bulletin.

(b) Data to be Submitted.

1. Medical Claims and Encounter Data. Payers shall report health care service paid claims and encounters for all Massachusetts resident members, and all members of a Massachusetts employer group including those who reside outside of Massachusetts. Payers must identify encounters corresponding to a capitation payment.

a. Payers will be not be required to submit denied claims.[1]

b. Payers must provide data and information for payments and financial transactions that do not utilize the claims system, including but not limited to:

i. encounters;
ii. amounts withheld for any reason;
iii. claims associated with risk-sharing arrangements
iv. paper-based claims;
v. pay-for-performance payments and
vi. claims not otherwise described

c. Payers must provide information according to the Submission Guide to identify the type of service and setting in which the service was provided. Each submitted data file shall have control totals and transmission control data.

2. Pharmacy Claims. Health Care Payers must provide data for all pharmacy paid claims for prescriptions that were actually dispensed to members and paid.

3. Dental Claims. Health Care Payers must provide data containing all dental claims and encounter data for members.

4. Member Eligibility Data. Health Care Payers must provide a data set that contains information on every covered plan member whether or not the member utilized services during the reporting period. The file must include member identifiers, subscriber name and identifier, member relationship to subscriber, residence, age, race, ethnicity and language, and other required fields to allow retrieval of related information from product, pharmacy, dental and medical claims data sets.

5. Provider Files. Health Care Payers must provide a file that includes standard identifiers such as provider name and locations, and standard identifier codes such as NPI, for hospital based services, ambulatory care, specialty providers and pharmacy providers.

6. Product Files. Health Care Payers must provide detailed information on covered services, group size, coverage levels, and copayments.

[1] ***Payers are not required to submit wholly denied claims. However, if a single claim line is denied within a paid claim that denied line should be reported.***

APCD Data Release Regulation

The following is extracted from **APCD Data Release regulation 114.5 CMR 22.00:**

22.01: General Provisions

(1) Scope and Purpose. 114.5 CMR 22.00 governs the disclosure of health plan information and claims data submitted by health care payers pursuant to 114.5 CMR 21.00. The purpose of 114.5 CMR 22.00 is to make health plan information and data available as a resource where such access serves the public interest while safeguarding the privacy rights of claims data subjects. Pursuant to M.G.L. c. 118G, §6, data submitted by health care payers are not a public record, and no public disclosure of any data and information shall be made except in accordance with the provisions of 114.5 CMR 22.00.

(2) Effective Date. 114.5 CMR 22.00 is effective on July 23, 2010.

(3) Authority. 114.5 CMR 22.00 is adopted pursuant to M.G.L. c.118G.

Public Use Files. Public Use Files are datasets derived from records submitted by payers pursuant to 114.5 CMR 21.00 that contain **de-identified member and utilization data elements** and **exclude payer identifiers**. Public Use Files contain **data elements that will not be disclosed unless the Division determines that an applicant fulfills the requirements imposed by 114.5 CMR 22.03**. See Appendix A for list of Public Use elements.

Restricted Use Files. Restricted Use Files are datasets derived from records submitted by payers pursuant to 114.5 CMR 21.00 that **contain data elements that will not be disclosed unless the Division determines that an applicant fulfills the requirements imposed by 114.5 CMR 22.03(2)**. See Appendix B for list of Restricted Use elements.

22.03: Procedures for Data Requests

(1) Public and Restricted Use Files. The Division will create **Claims Data Public Use Files and Restricted Use Files** to which Applicants may request access in accordance with 114.5 CMR 22.03(2).

(2) Application Review Procedures.

(a) Applications for Data.

1. All Applicants must submit a written application. Each Applicant shall:

a. **specify the data** requested, including Public Use Files and any restricted data elements requested;
b. specify the **purpose and intended** use of the data requested, including a **detailed project description** that describes any other data sources to be used for the project;
c. specify **security and privacy measures that will be taken** in order to safeguard patient privacy and to prevent unauthorized access to or use of such data;
d. specify **the Applicant's methodology for maintaining data integrity** and accuracy;
e. describe how the results of the Applicant's analysis will be **published**;
f. agree to **provide the results of all analyses, research, or other product of the data requested to the Division** for the Division's own use;
g. agree to the data disclosure **restrictions** in 114.5 CMR 22.04; and
h. obtain **prior approval from the Division to release any reports** that used restricted use files prior to publication or other release to another person or entity. The **Division will review the report** to determine whether the privacy rights of any data subject would be violated by the release of the report

2. Applicants for **Public Use Files** shall specify **which pre-developed module of public use files** is requested. Additional or customized public use files will only be provided at the Commissioner's sole discretion;

3. Applicants for **Restricted Use Files** must **demonstrate a need** for each restricted data element requested. The Division will release **only those restricted data elements which it determines to be necessary** to accomplish the applicant's intended use;

[4. **Applicants requesting Medicare data will be required to conform with CMS requirements to obtain and use applicable data.]**[2]

[5. Medicaid data will not be released in response to any application, unless the release of such data conforms to all applicable federal and state laws and regulations, including laws and regulations governing the de-identification of such data, and any data release restrictions in the agency's interagency service agreement.][3]

6. The Division will **post applications on the Division's website**. The Division will not post those portions of applications that specify security measures or applications from law enforcement entities to the extent that posting the application on the website may impede the investigatory process. The Division will **invite public comments on applications for at least 10 business days** following the day on which the application is posted on the website. Public comments that comply with all applicable internet policies for public posting will be posted on the Division's website.

(b) Data Release Criteria. The Commissioner will **approve an application if** he or she determines that:

1. the purpose for which the data is requested is **in the public interest**. Uses that serve the public interest include, but are not limited to: health cost and utilization analysis to formulate public policy; financial studies and analyses of provider payment systems; utilization review studies; health planning and resource allocation studies; and studies that promote improvement in health care quality or a mitigation of health care cost growth.

2. the applicant has demonstrated it is **qualified** to undertake the study or accomplish the intended use;

3. the applicant **requires such data in order to undertake** the study or accomplish the intended use; and

4. the applicant can ensure that **patient privacy** will be protected.

(c) Data Release Committee. The Commissioner shall establish a **Data Release Committee** to advise the Commissioner on individual applications for claims data upon the request of the Commissioner. In addition, the Committee provides advice on best practices regarding claims data release and data protection policies.

1. The Committee shall include, but not be limited to, **representation of health care plans, providers, and consumers**. The Commissioner may appoint additional members to the Committee.

2. The Commissioner shall **convene the Committee as necessary**, and **post the agenda of the Committee on the Division's website**. When convening the Data Release Committee, the Commissioner shall concurrently consult with one or more representatives of the state agencies that participate through intergovernmental services agreement(s) in 114.5 CMR 21.00.

3. Advice issued by the Data Release Committee is not binding on the Commissioner.

4. The Division will **post information about the Data Release Committee's membership**, scheduled meetings and meeting agendas on the Division's website.

(d) The Commissioner's decisions to approve or deny claims data release applications are final and not subject to further review or appeal.

(e) The Commissioner may impose conditions on the subsequent use and disclosure of data released under 114.5 CMR 22.00.

(3) The Division may **charge a fee** to all applicants requesting claims data, as established under M.G.L. c. 7, § 3B and approved by the Executive Office for Administration and Finance. Established fees shall reflect the total cost of systems analysis, program development, computer production costs incurred in producing the requested data, vendors' fees, consulting services, and any other costs related to production of the requested data. Fee schedules will be issued by the Division by Administrative Bulletin and updated from time to time. The fee may be waived for the following entities:

(a) CMS;

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[2] **Medicare data is not included in the 10/31/2012 APCD Data Release.**

[3] **Medicaid data is not included in the 10/31/2012 APCD Data Release.**

(b) an agency of the Commonwealth; or
(c) researchers who can demonstrate that imposition of a fee would constitute an undue hardship.

22.04: Data Disclosure Restrictions

(1) Required Assurances. All applicants shall provide the Division with **written assurances** that:

(a) data will be used **only for the purpose stated in the request**;

(b) **no attempt** will be made to use any data supplied to ascertain the identity of specific insured individuals or patients;

(c) restricted data elements will **not be released to any other person or entity** except as specified in 114.5 CMR 22.04(2); and

(d) the applicant will obtain these assurances in writing from any recipient of data or agent that processes data on behalf of the applicant.

(2) Other Government Agencies. The Division may release claims data to:

(a) a state agency or authority which has, pursuant to its statutory or regulatory authority, directed third parties to submit data as required by statute, regulation or contract, to the Division in fulfillment of its legal or regulatory obligation. The Division will release claims data only to the state agency or authority with such legal authority, or as directed by such agency or authority to legally authorized entities.

(b) organizations under contract with the Division to undertake studies; and

(c) other government agencies whose applications meet the criteria set forth in 114.5 CMR 22.03.

(3) Other Disclosures. **The Division or its agent may release draft reports or other analyses** that contain or use restricted use claims data for review and comment. If the Division or its agent provides an individual or entity with a draft report or other analysis for review and comment, the contents of such report or the analysis contained in such report are confidential, and may not be disclosed without prior approval by the Division. The report must conform to the standards for de-identification set forth under 45 CFR 165.514(a), (b)(2), and (c).

22.05: Other Provisions

(1) Administrative Bulletins. The Division may, from time to time, issue Administrative Bulletins to clarify its policy on substantive provisions of 114.5 CMR 22.00. In addition, the Division may issue Administrative Bulletins to specify the filing requirements under 114.5 CMR 22.00.

(2) Confidentiality. **The Division shall institute appropriate administrative procedures and mechanisms to ensure that it is in compliance with the provisions of M.G.L. c. 66A, to the extent that the claims data collected is "personal data" within the meaning of that statute, and the security provisions of the Health Insurance Portability and Accountability Act. In addition, the Division shall ensure that any contractor or third party that processed or analyzes the data shall comply with these statutory requirements.**

(3) Sanctions. If an approved Applicant fails to comply with any of the requirements and conditions for receiving restricted claims data in 114.5 CMR 22.00, the Division may:

(a) **deny** future access to claims data;
(b) **terminate** current access to all claims data; and/or
(c) demand and secure the **destruction or return of all claims data**

(4) Penalties. An approved Applicant that fails to comply with the requirements of 114.5 CMR 22.00 will also be subject to **all penalties and remedies allowed by law**, including M.G.L. c. 214, § 3B. The Division will notify the Attorney General's Office and the U.S. Department of Health and Human Services Office for Civil Rights of any violations of the provisions of 114.5 CMR 22.00.

22.06 Severability

The provisions of 114.5 CMR 22.00 are severable. If any provision or the application of any provision is held to be invalid or unconstitutional, such invalidity shall not be construed to affect the validity or constitutionality of any remaining provisions of 114.5 CMR 22.00 or the application of such provisions.

REGULATORY AUTHORITY
114.5 CMR 22.00: M.G.L. c.118G

Data Collection Effort

History

Establishment of the Massachusetts APCD

The Massachusetts Health Care Quality and Cost Council was established, pursuant to legislation in 2006, to monitor the Commonwealth's health care system and disseminate cost and quality information to consumers. Since then there have been nationwide efforts by government, private, non-profit, and academic organizations focused on improving the development and deployment of **state-based all payer claims databases (APCD)**. Currently, there is participation from more than a dozen states.

Unlike other Massachusetts agencies, M.G.L. c. 118G, §§ 6 and 6A provide the **Division of Health Care Finance and Policy (DHCFP)** with broad authority to collect health care data.

On July 1, 2009, the DHCFP assumed responsibility for receiving secure file transmissions, creating, maintaining and applying edit criteria, storing the edited data and creating analytical public use files, for the Health Care Quality and Cost Council (HCQCC). By July 2010, Regulations 114.5 CMR 21.00 and 114.5 CMR 21.00 became effective, establishing the APCD in Massachusetts. The Massachusetts APCD is one of several APCD's in the United States.

What is an all-payer claims database (APCD)?

- Components include medical claims, dental claims, pharmacy claims, and information from member eligibility files, provider files, and product files.
- It includes fully-insured, self-insured, Medicare, and Medicaid data.
- It also includes clear definitions of insurance coverage (covered services, group size, premiums, co-pays, and deductibles) and carrier supplied provider directories.
- It protects and de-identifies personal and sensitive information.

The result is a dataset that allows a broad understanding of cost and utilization across institutions and populations:

Providing objective analysis on health care costs and quality

- The APCD will provide timely, valid, and reliable health care claims data for the purposes of:
  - informing the development of health care policies in the Commonwealth.
  - informing the development of performance measures to evaluate payment methodologies and support integrated health care delivery models.

Facilitating administrative simplification

- The APCD will serve as the central repository for all health care claims submission for Massachusetts state agencies. Massachusetts payers can submit claims data to the APCD, and DHCFP will provide the required data extracts to sister agencies, which will result in administrative simplification for payers.
- The Massachusetts technical specifications for submissions are aligned with APCD efforts in other states, particularly in New England, where payers may be subject to compliance from multiple states.
- This positions Massachusetts, with other New England states, to serve as a regional and national model for data specifications that will facilitate further savings.

Promoting transparency initiatives

- The availability and release of all-payer claims data in pre-determined modules will enhance public and private research projects related to cost, medical service utilization, health care quality, and comparative effectiveness in order to facilitate transparency within the Massachusetts health care delivery system.

Supporting nationwide efforts

- DHCFP's development of an APCD is consistent with a growing national trend. According to the APCD Council, over thirty states either have or are building an APCD, or have expressed strong interest in APCDs. The Division supports the APCD Council's harmonization efforts and their advocacy for and development of standards for APCD data collection nationwide.

Broad Caveats

Researchers using the 10/31/2012 APCD data should be aware of the following caveats with the current data release.

- Release files include data submitted to the Division through February, 2012. Data submitted to the Division after February, 2012 is NOT included in the files.
- Carriers may petition for variances on compliance levels for ALL APCD data elements. Each approved variance allows a carrier to submit a LOWER LEVEL of VALID VALUES for the requested data element. All users of the data should refer to the VARIANCE PROCESS section of this document and review the amount of variance requests submitted for each requested data element.
- This is a PRELIMINARY RELEASE of data which has been expedited for use by external stakeholders. The release files contain the data submitted to the Division including BOTH VALID and INVALID values. All users of this preliminary data are strongly encouraged to review the EDITS section of this document and the contents of each data element with the full understanding it may include invalid values.
- Claim Files collected for **January 2008 through June 2010** were accepted with **relaxed Edits**. (Refer to EDITS section of this document.)
- Note that MEDICAID AND MEDICARE DATA ARE NOT PART OF THE RELEASE. THEY MUST BE APPLIED FOR SEPARATELY FOR APPROVAL BY CMS, MASSHEALTH, AND THE EXECUTIVE DIRECTOR.
- Some Release Data was manipulated for compliance with HIPAA:
    - Masking of ID Codes and fields containing identifying data
    - Redaction of specific values that may contain identifying data
    - Member Birth Year is reported as 999 for all records where the member is older than 89 years

APCD RELEASE FILE OVERVIEW

The **APCD** is comprised of data elements collected from **all Private and all Public Payers** of eligible **Health Care Claims** for Massachusetts Residents. Data is collected in six file types: **Products (PR)**, **Member Eligibility (ME)**, **Medical Claims (MC)**, **Dental Claims (DC)**, **Pharmacy Claims (PC)**, and **Providers (PV)**.

- Data is currently available for release from three years of warehoused data as of February, 2012: **2008, 2009, and 2010. All APCD data elements** are classified for the Release as either **Public**, **Restricted**, or **not available**: refer to the **File Layout** section included in this document for a complete list by file type and classification.
- Certain identifying or sensitive data elements are **Masked** in the release. Some of these elements are combined with Payer Identifiers and then masked, creating unique identifiers to allow researchers to link related elements within the same file or between the various file types, or to link to Carrier-specific lookup tables for field value descriptions, while maintaining confidentiality for payers, providers, and individuals. Refer to the **Linkage** section in this document for more information**.**
- In some cases, data elements have been added to the APCD database for the Release which are derived from Submission data elements (e.g. birth year), or have been added to the database to aid in versioning and identifying Claims (e.g. Unique Record IDs and status flags). Refer to the **File Layout** section for detail.
- Data submitted to the Division after February, 2012 is not included in this release.
- Medicare and Medicaid data is not included in this release.

The following steps have been taken to prepare APCD data warehouses for the Release:

1. **Create Annual Claims files (Medical, Pharmacy, and Dental).**

   Annual claim files are based on calendar year submission period. For example, the 2010 Medical Claims file contains all claims with monthly submission periods between 1-1-2010 through 12-31-2010.

   APCD Versioning has been applied to claims files to identify the most recent version of each claim line. (Refer to the Versioning section of this document.)

2. **Create Annual Member Eligibility files.**

   Annual eligibility files contain all eligibility records with at least one day of member eligibility within the calendar year. For example, the 2010 eligibility file contains all records with at least one day of eligibility between 1-1-2010 and 12-31-2010.

   - Each Submission File contains 24 months of eligibility data.
   - December 2009 submission files were used for 2008 eligibility data and December 2010 submission files were used for 2009 and 2010 eligibility data.

   Exact physical duplicates were removed.

3. **Create Annual Provider files.**

   Annual provider files contain all provider records active for at least one day of the calendar year. For example, the 2010 provider file contains all records with at least one active day between 1-1-2010 and 12-31-2010. **Exact physical duplicates** were removed.

4. **Create Annual Product files.**

   Annual product files contain all product records active for at least one day of the calendar year. For example, the 2010 product file contains all records with at least one active day between 1-1-2010 and 12-31-2010. **Exact physical duplicates** were removed.

File Types

Information about each file type is included in the following sections, listing the types of data collected in each file, explanation of file structure, and answers to frequently asked questions (FAQ) from submitters about data requirements.

Product File

As part of the APCD carriers are required to submit a **Product** file. This is a file type that has not been previously requested of carriers.

Below are details on business rules, data definitions and the potential uses of this data. **For a full list of elements refer to the File Layout section**.

Types of Data Collected in the Product File:

Product Identifiers

The Division has made a conscious decision to collect elementary identifiers that may be associated with a Product. The data in fields PR002 through PR008 can be used when analyzing Product data across carriers. The identifiers will be used to help link Product data to the Member's Eligibility File.

Deductibles

The Division collects deductible band-width information. Additional data elements such as Coinsurances and Co-pays are reported in other file types.

Dates

The Division collects two date fields for each Product record.

The Begin and End Date for each Product describes the dates the Product was active with the carrier and usable by eligible members. For Products that are still active the End Date should be Null. For Products that are not active but may still have claims being adjudicated against them, the End Date should be the End Date reported to the Division of Insurance OR the date the license was terminated.

Product Release File Structure and FAQ:

Following is information previously published for Carriers' FAQ's about the business rules, data definitions and potential uses of the **Product File,** as well as new information points about the Release Data:

Issue	Clarification
Frequency of submission	Quarterly
Release File Format	Release files will be in an **asterisk delimited text file**. **Public Release File:** • Data Elements will be delimited in the order outlined in the File Layout section of this document. • Any empty columns will be included in the specified order and will have no spaces or characters between the asterisks. **Restricted Release File:** • Only the requested and approved Data Elements will be included in the release file. • Released elements will be delimited in the same order as is found in the File Layout section of this document.

<table>
<tr><th>Issue</th><th>Clarification</th></tr>
<tr><td>Rows</td><td>Each row is supposed to represent a unique instance of a Product. However some Carriers have reported products that differ only in aspects which are not defined by the APCD Product file elements, and therefore there may be multiple product lines that appear to be duplicate rows, but are not according to these carriers.</td></tr>
<tr><td>Product definition</td><td>A Product starts as a base offering, often described by a business model that it conforms to, e.g.: HMO, PPO, Indemnity, etc.

A generally accepted table is included as the lookup table for data element PR004. Refer to the File Structure section of this document.</td></tr>
<tr><td>Products or lines of business not included in the lookup table for PR004</td><td>For other lines of business the Carriers will report the following:
<table>
<tr><th>Element</th><th>Element Name</th><th>Submission Guideline</th></tr>
<tr><td>PR004</td><td>Product Line of Business</td><td>ZZ</td></tr>
<tr><td>PR007</td><td>Other Product Benefit Description</td><td>Carriers may enter the name of the business model here</td></tr>
</table>
By reporting the Model Code of ZZ (mutually defined) the Carrier will be able to report the name of the business model in PR007. The Division realizes that carriers store their Product data in a variety of formats and data structures. The Division feels this methodology will provide the most flexibility to analyze Product data.</td></tr>
</table>

FAQ	Response
Is the intent of the (PR001) Product ID to identify a unique combination of values across all the fields in the file? **Alternatively, could Carriers provide multiple rows with different Product IDs and Product names (PR002) but the same values in all other fields (i.e., exact duplicate rows except for product ID and name) or would these get rejected?**	DHCFP accepts multiple rows with different Product IDs and Product Name (PR002) but the same values in all other fields. This would indicate that the product is either branded differently to certain accounts, although it has the same base characteristics, or that some of the specifics of the product may differ from one Product ID to another, e.g.: no deductible for lab tests in one product while the other product has a $200 lab deductible.
Is DHCFP's main interest for the Product File to understand benefits related to deductibles and drug coverage?	No. There are multiple reasons for the Division collecting product information including: • linking patient costs and utilization to specific products • the various characteristics of those products
Is it possible the Product file will be expanded at some point in the future in order to capture other types of benefits (e.g.: co-pay levels, deductibles by service type, OOP max, coinsurance, etc...)?	Yes, it is possible the Division will expand the product file, or alternatively ask for a supplemental product data feed to further support Product file analysis.

As part of the All Payer Claims Database (APCD) carriers are required to submit a Member Eligibility file. The Division of Healthcare Finance and Policy (Division), in an effort to decrease any programming burden, has adopted a file layout currently in use by another state.

Below are details on business rules, data definitions and the potential uses of this data. For a full list of elements refer to the File Layout section.

Following are the submission requirements for 2008-2010 and beyond:

Filing Name	Filing Frequency	Initial Requirement
ME Eligibility File - Initial legacy filing	Initial	Two 24 month historical Eligibility files that include all persons eligible for any part of the timeframe between 1/1/2008 and 12/31/2010. • First file covers eligibility 1/1/2008 to 12/31/2009 • Second file covers 1/1/2009 to 12/31/2010.
ME Eligibility File beginning 2011	Monthly	A complete historical file reporting back on a 24 month rolling base.

Types of Data Collected in the Member Eligibility File:

Subscriber / Member Information

Both member and subscriber information is collected in the file; however, the eligibility information is related strictly to the **member**, who may or may not be the subscriber. The subscriber information is mainly used to link the member to a subscriber, and is a requirement of other states.

Non-Massachusetts Resident

The Division will not require payers submitting claims and encounter data on behalf of an employer group to submit claims data for employees who reside outside of Massachusetts, unless the payer is required by contract with the Group Insurance Commission to submit paid claims and encounter data for all Massachusetts residents, and all members of a Massachusetts employer group including those who reside outside of Massachusetts.

Demographics

The Division is collecting birth date information on each Subscriber and Member. This information is also useful with matching algorithms.

Coverage Indicators

The Division is collecting coverage indicator flags to determine if a member has medical, dental, pharmacy, behavioral health, vision and/or lab coverage. These fields may be compared against the Product file and will be helpful in understanding benefit design.

Provider Identifiers

The Division has made a conscious decision to collect numerous identifiers that may be associated with a provider. The data in fields ME036 through ME039, and ME046 through ME048, will be used by the Division when analyzing data across carriers.

Dates

The Division is collecting two sets of start and end dates.

- ME041 and ME042 are the dates associated with the **member's enrollment with a specific product**. ME041 captures the date the member enrolled in the product and ME042 captures the end date or is Null if they are still enrolled.
- ME047 and ME048 are the dates a **member is enrolled with a specific PCP**. For plans or products without PCPs, these fields will not be evaluated.

Member Eligibility Release File Structure and FAQ:

Issue	Clarification
Frequency of submission	Monthly, but representing eligible persons over a rolling 24 month period. Each new file is a complete historical file. Each new monthly submission contains the same contents as prior, inclusive of any record updates or new eligible persons, and going back 24 months.
Release File Format	Release files will be in an **asterisk-delimited text file**. **Public Release File:** • Data Elements will be delimited in the order outlined in the File Layout section of this document. • Any empty columns (elements) will be included in the specified order and will have no spaces or characters between the asterisks. **Restricted Release File:** • Only the requested and approved Data Elements will be included in the release file. • Restricted released elements will be delimited in the same order as is found in the File Layout section of this document.
Rows	Each row represents a **unique instance of a Member and their Product Eligibility** and attributes. ▪ If a Member is eligible for more than one Product, then the Member will be reported again on another record in the same month. ▪ If a Member has more than one PCP under the same Product, then the Member and Product will be reported again on another record in the same month. ▪ If a member has a break in eligibility, this would require multiple records. This allows the opportunity to analyze information on Member Eligibility to Products and Member Eligibility to Claims, to better understand utilization. Accurate enrollment data is needed to calculate member months by product and by provider.

	• ME file detail level is defined as **at least one record per member, per product id, per begin and end date of eligibility for that product**.
	• Multiple records for "Member + Product" may exist, but begin and end eligibility dates should not overlap.
	• Only a product change, or break in eligibility triggers a requirement for a new eligibility record.
	• Changes in attributes such as PCP will be lost in the legacy (2008 – 2010) period but will be captured going forward.
	• Note that **coverage attributes** such as PCP should reflect the values most relevant to:
	  o the **end period** for the Eligibility segment (if an inactive segment) or
	  o the Member Eligibility file **end period**, e.g.:
	  ▪ 12/31/2009 for first legacy filing
	  ▪ 12/31/2010 for the second legacy filing

Issue	Clarification
Unique Record ID	• A Unique Record ID for each eligibility record will be assigned by the Division. • All public and restricted use files will contain the unique record ID to enable linking between the records in the public use file and the restricted use file.
Example of multiple rows in the ME file:	The ME file should contain one record per member per product per eligibility time period. If medical and pharmacy benefits are delivered via two separate products rather than a bundled product (e.g.: HMO Medical 1000 and RX Bronze) we expect two records, one for HMO Medical 1000 and one for RX Bronze. The Prescription Drug Coverage indicator (ME019) would have a value of '2' for No in the HMO Medical 1000 eligibility record, and the Medical Coverage indicator (ME020) would have a value of '1' for Yes. Those two field values would be reversed in the RX Bronze eligibility record. Each product would also need to be in the Product File, with PR006 indicating that the product is a Pharmacy, Medical or other product. We would expect the product Benefit Type to correlate to the flags in the Eligibility File. For example for the Product File record for the HMO Medical 1000 we would expect PR006 product Benefit Type to be '1' which equals a description of 'Medical Only' and RX Bronze's Product File record would have a value of '2' for 'Pharmacy Only' in PR006.
Redundancy with the Claims file data elements	Many of the segments in the file use similar semantics to claims data, and some fields are exact duplicates of fields on the claim file. The Division is seeking what is in the Carrier's Member File regardless of the information that comes in on Claims. This extra or similar information across files is needed to support analysis of the variations of Member Eligibility, and is also a requirement of other states.
Some companies do not track Member's date of death.	The intent of collecting this data element is to aid with ending a Member's Eligibility, regardless of place of expiration. Report when known.
There are a number of elements in the file layout that do not apply to some carriers.	Individual elements each have a reporting threshold setting, which allows Carriers to meet reporting requirements. The Division realizes that the current format does not fit all Carriers. The **variance process** allows for Carriers to address any inability to meet threshold requirements.
If claims are processed by a third-party administrator, who is responsible for submitting the data and how should the data be submitted?	In instances where more than one entity administers a health plan, the health care carrier **and** third-party administrators are responsible for submitting data according to the specifications and format defined in the Submission Guides. This means that some records may be represented twice – once by the carrier, and once by the TPA. The Division's objective is to create a **comprehensive** All-Payer database which must include data from all health care carriers and third-party administrators. Future releases planned by the Division will consolidate duplicative eligibility and claims reporting to remove duplication and provide one set of the most complete and accurate data.

FAQ	Response
How often should a carrier submit the Last Activity Date (ME056) field in the eligibility file?	Last Activity Date was a field of interest by GIC, and therefore only required of GIC carriers. Carriers submit the last activity date relevant to an eligibility change.

FAQ	Response
Please provide clarification on the meaning of Disease Management Flag (ME053) on the eligibility file?	This field is used to identify whether a member with a chronic condition (Diabetes, Asthma, Depression, COPD, and CHF) is participating in a health management program, care coordination, or health coaching and wellness program that the health plan sponsors either internally or through the use of an external vendor. For example, the member has asthma and participates in an asthma management program, or the member was identified as having high clinical risks due to multiple chronic conditions and participates in a health coaching program to ensure proper health education and access to preventive care and exams.
If a member enrolled in the product prior to 1/1/2008, should the carrier report that original enrollment date in field ME041 (product enrollment date) or should the carrier= report 20080101?	Carriers should report the original date of the member's enrollment in the product, even if it is prior to 2008.
Field ME050 (Member Deductible Used) is asking for "the amount to date the member has paid into deductible". Should that amount reported include the deductible paid over the entire span of time reported in fields ME041 and ME042 (Product Enrollment Start and Product Enrollment End) or only the most recent plan year within the product enrollment start and product enrollment end dates?	This field should represent **the current value of the Annual deductible incurred** pertinent to the timeframe which it represents. Examples are presented below. **<u>On the legacy files for 2008-2010</u>** For the file ending 12/31/09 ME050 represents the EOY 2009 deductible incurred by the member for 2009 [EOY: End of Year]; For the file ending 12/31/10 ME050 represents the EOY 2010 deductible paid for 2010 **<u>Going forward beginning January 2011:</u>** File ending 01/31/11 ME050 represents the end Jan 2011 deductible incurred by the member for 2011. This field will be cumulative over the course of the year if the member incurs more deductible charges.
Did the Division want carriers to report (ME050) Member Deductible Used on a paid or incurred basis?	The Division did not expect the payer to contact the provider to see if the member paid their deductible to the provider. The value in this field represents **the patient's deductible responsibility for claims that have been paid by the carrier**.
What is the formula carriers should have used to report Member Deductible (ME049)?	Carriers were to submit the **maximum amount the member would pay out of pocket** towards in-network deductibles for the annual time period. Out of pocket costs for co-pay or coinsurance are excluded from this calculation. This deductible amount applies to all possible benefit deductibles. If the maximum individual deductible is $2000 for the year, $2000 would be reported in the field.
If Product Enrollment Start Date (ME041) and Product Enrollment End Date (ME042) spans multiple plan years, do carriers populate ME049 (Member Deductible) with the plan year deductible times the number of plan years spanned by ME041 and ME042 or just a single plan years deductible?	Carriers submit the deductible for the **latest plan year to date**.

FAQ	Response
What amounts should have been reported in the Deductible fields, (ME111-ME116). Is it based on incurred or paid data?	The eligibility deductible fields specific to each benefit are not based on actual patient deductibles incurred or paid. These fields indicate t**he maximum amount that the member's product, group and/or contract require for certain types of services**. For example if a member had a maximum annual deductible of $2000 per year across all services, but there is up to $1500 medical deductible, and up to a $750 deductible for pharmacy and $300 for dental, and $200 for behavioral health, the Division needs to see the maximum amount related to each deductible type, and understands that the maximum out of pocket deductible will not exceed $2000 based on the value in ME049 (Member Deductible).
Does race and ethnicity need to be self-reported by the member? Can a carrier use derived race and ethnicity values using surname analysis and/or geo-coding software?	Race and ethnicity data should be self-reported by the member. A carrier may not submit data derived by surname analysis, geo-coding software, and/or any other methodology without the Division's prior approval.

Medical Claims File

As part of the All Payer Claims Database (APCD) carriers are required to submit a Medical Claims File.

Below are details on business rules, data definitions and the potential uses of this data. For a full list of elements refer to the File Layout section.

Types of Data Collected in the Medical Claims File:

Carrier-assigned Identifiers:

The Division requires various **Carrier-assigned identifiers** for matching-logic to the other files, i.e., Product File, Member Eligibility. Examples of this field include MC003, MC006, MC137 and MC141 will be used by the Division to aid with the matching algorithm to those other files.

Claims Data:

The Division requires the line-level detail of all Medical Claims for analysis. The line-level data aids with understanding utilization within products across Carriers. The specific medical data reported in MC039 through MC062, MC071, MC072, MC075, MC083 through MC088, MC090, MC108, MC109, MC111, MC126, MC127, MC129, MC130, and MC136 would be the same elements that are reported to a Carrier on the UB04, HCFA 1500, the HIPAA 837I and 837P or a Carrier specific direct data entry system.

Subscriber and Member (Patient) Carrier unique identifiers are requested to aid with the matching algorithm, see MC137 and MC141.

Fields MC024-MC035 - Servicing provider data:

The set of fields MC024-MC035 are all related to the servicing provider **entity**. The Division wishes to collect entity level rendering provider information here, and at the lowest level achievable by the carrier.

If the carrier only knows the billing entity, and the billing entity is not a ***service rendering*** provider, then the billing provider data (MC076-MC078) is ***not*** appropriate. In this case the carrier would need a variance request for the service provider fields.

If the carrier only has the data for a main ***service rendering*** site but not the specific satellite information where services are rendered, then the main service site ***is*** acceptable for the service provider fields.

For example – XYZ Orthopedic Group is acceptable, if XYZ Orthopedic Group Westside is not available. However, XYZ Orthopedic Group Westside is preferable, and ultimately the goal.

A physician's office is also appropriate here, but not the physician. The physician or other person providing the service is expected in MC134.

Fields MC134 Plan Rendering Provider and MC135 Provider Location:

The intent of these fields is to capture servicing or rendering provider at the physician or other licensed person rendering level. These fields should describe precisely who and where the service was rendered. If the carrier does not know who actually performed the service or the specific site where the service was actually performed, the carrier will need a variance request for one or both of these fields. It is not appropriate to load facility or billing information here.

Non-Massachusetts Residents:

The Division does not require payers submitting claims and encounter data on behalf of an employer group to submit claims data for employees who reside outside of Massachusetts, unless the payer is required by contract with the Group Insurance Commission to submit paid claims and encounter data for all Massachusetts residents, and all members of a Massachusetts employer group including those who reside outside of Massachusetts.

Adjudication Data:

The Division requires adjudication-centric data on the file for analysis of Member Eligibility to Product. The elements typically used in an adjudication process are MC017 through MC023, MC036 through MC038, MC063 through MC069, MC071 through MC075, MC080, MC081, MC089, MC092 through MC099, MC113 through MC119, MC122 through MC124, MC128, and MC138 and are variations of paper remittances or the HIPAA 835 4010.

The Division has made a conscious decision to collect numerous identifiers that may be associated with a provider. The provider identifiers will be used to help link providers across carriers in the event that the primary linking data elements are not a complete match. The existence of these extra identifying elements in claims is part of our quality assurance process, and will be analyzed in conjunction with the provider file. We expect this will improve the quality of our matching algorithms within and across carriers.

Denied Claims

Payers are not required to submit wholly denied claims.

The Provider ID

Element MC024 (Service Provider ID), MC134 (Plan Rendering Provider) and MC135 (Provider Location) are some of the most critical fields in the APCD process as it links the Provider identified on the Medical Claims file with the corresponding Provider ID (PV002) in the Provider File. The definition of the PV002 field is:

The unique number for every service provider (persons, facilities or other entities involved in claims transactions) that a carrier has in its system. This field is used to uniquely identify a provider and that provider's affiliation and a provider and a provider's practice location within this provider file.

The goal of PV002 is to help identify provider data elements associated with provider data that was submitted in the claim line detail, and to identify the details of the Provider Affiliation.

Medical Claims Release File Structure and FAQ:

Following is information previously published in FAQ's about the **Medical Claims File,** as well as new information points about the Release Data:

Issue	Clarification
Frequency of Submission	Medical claim files are submitted monthly.
Release File Format	Release files will be in an **asterisk-delimited text file**. **Public Release File:** • Data Elements will be delimited in the order outlined in the File Layout section of this document. • Any empty columns will be included in the specified order and will have no spaces or characters between the asterisks. **Restricted Release File:** • Only the requested and approved Data Elements will be included in the release file. • Restricted release elements will be delimited in the same order as is found in the File Layout section of this document.
Rows	Each row in the APCD Medical Claims file represents one **claim line**. If there are multiple services performed and billed on a claim, each of those services will be uniquely identified and reported on a line. It is necessary to obtain line item data to better understand how services are perceived and adjudicated by different carriers.

<table>
<tr><th>Issue</th><th>Clarification</th></tr>
<tr><td>Unique Claim Line Id</td><td>A unique id for each claim line in the data release will assigned by the Division.

All public and restricted use file records will contain unique record id's to enable linking between the records in the public use file and the records in the restricted use files.</td></tr>
<tr><td>Redundancy:</td><td>Certain data elements of claim level data will be repeated in every row in order to report unique line item processing.

Claim-line level data is required to capture accurate details of claims and encounters.</td></tr>
<tr><td>Changes to Claim Lines</td><td>Claim line Versioning is triggered by the Claim Line Type field:
<table>
<tr><th>Claim Line Type Code</th><th>Claim Line Type Description</th><th>Action/Source</th></tr>
<tr><td>O</td><td>Original</td><td></td></tr>
<tr><td>V</td><td>Void</td><td>Delete line referenced / Provider</td></tr>
<tr><td>R</td><td>Replacement</td><td>Replace line referenced / Provider</td></tr>
<tr><td>B</td><td>Back Out</td><td>Delete line referenced / Payer</td></tr>
<tr><td>A</td><td>Amendment</td><td>Replace line referenced / Payer</td></tr>
</table>
Refer to the Versioning section of this document for more information.</td></tr>
<tr><td>Final Version flag</td><td>Final Version flag has been added to the APCD by DHCFP and will be included in the Public data release set for all Claims files.

• This flag indicates the highest version of a claim line. The flag is set as the final step of the Versioning process.
• Refer to the Versioning section of this document for more information.

As a result of changes submitted for claim lines, there may be several versions of a Claim Line in the database. The APCD data release includes all payer-submitted Claim Lines regardless of duplicates and Claim Line Type.

The Final Version flag indicates which Claim Lines should be included in the final version of a Claim, to the best of the ability of the Division's current process. If the final version of a claim is a void, no flag is set.</td></tr>
<tr><td>Claim ID</td><td>Medical Claims may be identified as follows:

Public data release:

• Claim lines may be grouped by the Combined Masked field for Payer/Member or Payer/Subscriber, but separate claims may not be identified as such.

Restricted data release:

• Claims may be isolated by grouping claim lines by the following elements:
o MC004 Payer Claim Control Number (Restricted and Masked)
o Payer Org Id MC001 (Restricted and Masked)</td></tr>
</table>

Issue	Clarification
Denied claim lines	Wholly denied claims should not be reported at this time. However, if a **single procedure** is denied within a paid claim that denied line should be reported. Denied line items of an adjudicated claim aid with cost analysis.
Claims that are paid under a '**global payment', or 'capitated payment',** thus zero paid	Any medical claim that is considered 'paid' by the carrier should appear in this filing. Paid amount should be reported as 0 and the corresponding Allowed, Contractual, Deductible Amounts should be calculated accordingly. The reporting of Zero Paid Medical Claims is required to accurately capture encounters and to further understand contractual arrangements.
Previously paid but now **Voided** claims	Claims that were paid and reported in one period and voided by either the Provider or the Carrier in a subsequent submission period are reported in the file. The reporting of Voided Claims maintains logic integrity related to medical costs and utilization.
Institutional and **Professional** claims: What **types** of claims are to be included?	The Medical Claims file is used to report both **institutional** and **professional** claims. The unique elements that apply to each are included; however **only those elements that apply to the claim type should be submitted**. Example: Diagnostic Pointer is a Professional Claim element and would not be a required element on an Institutional Claim record. See **MC094** below for **claim type ID**.
The word **'Member'** is used in the specification. Are **'Member'** and '**Patient'** used synonymously?	Yes. **Member** and **Patient** are to be used in the same manner in this specification
Claims processed by a **third-party administrator:** who is responsible for submitting the data and how should the data be submitted?	In instances where more than one entity administers a health plan, **the health care carrier AND third-party administrators are responsible for submitting data** according to the specifications and format defined in the Submission Guides. This means that some records may be represented twice – once by the carrier, and once by the TPA. The Division's objective is to create a **comprehensive** All-Payer database which must include data from all health care carriers and third-party administrators. Future releases planned by the Division will consolidate duplicative eligibility and claims reporting to remove duplication and provide one set of the most complete and accurate data.

Medical Claims File FAQ	Response
What is the difference between fields MC099 (Non-Covered Amount) and MC114 (Excluded Expenses). Is this the dollar amount charged that is above the plans limitations?	APCD defines **Non-covered Amount** as: Items and/or services that are **not covered by the carrier** as part of the contract/eligibility/benefit and denied upon supplier or provider claim submission. APCD defines **Excluded Expenses** as: Items and/or services that are **typically covered by the carrier** as part of the member's contract/eligibility/benefit but at the claim level have been **over-utilized or delivered by a non-approved, non-credentialed supplier or provider.**
Fields MC024-MC035 captures data related to the **servicing provider**. If carrier only stores information related to **billing provider**, may this be stored in these fields?	No. If the billing provider is strictly a billing entity, and is not a provider of services, we would not want that information repeated in the service provider fields. See clarifications of **Servicing and Plan Rendering provider fields** in the **Types of Data** section for **Medical Claims**.

Medical Claims File FAQ	Response
For **Field MC117 Authorization Required,** is the state asking for services that **had authorizations**, or for services that **required authorizations,** whether the authorization was requested and approved or not?	For claims which **required a pre-authorization** the value in this field should be '1' for Yes.
What files must a standalone Behavioral Health carrier submit?	For standalone Behavioral Health carriers who offer either direct benefits to group accounts or individuals, or benefits via a contract with a medical carrier, the carrier submits behavioral health claims using the Medical File format, along with a Member Eligibility, Provider and Product File. Stand-alone carriers are able to submit variance requests for data elements that they feel are not applicable to their business model.
Does a medical carrier need to submit vision claims?	Vision claims that are covered under a health plan's medical product are submitted along with the Medical Claims File in the medical claims format. On the Eligibility File, the Vision Benefit Indicator (ME118) would be equal to '1' for Yes. If the Vision Provider is contracted directly with the medical carrier, we would expect a record in the Provider file as well for the providers. Some fields in the Medical File are not applicable for vision claims, but vision claims are expected to be an extremely small percentage of claims. Detail on standalone vision carriers' submissions is provided in the next question.
What files must a standalone vision carrier submit?	For standalone vision carriers who offer either direct benefits to group accounts or individuals, or benefits via a contract with a medical carrier, it is expected that the vision carrier will submit vision claims using the Medical File format, along with a Member Eligibility, Provider and Product File. Stand-alone carriers are able to submit variance requests for data elements that are not applicable to their business model. The variance should state a Proposed Threshold of 0% with all the other proper columns filled out. The Rationale in Column I of the variance request will indicate that the data elements requested are not applicable to a Vision Carrier. No variance request is necessary for the Dental and Pharmacy files. The Organization Submitter ID (OrgID) indicates which files a carrier is required to submit.
If a Vision Carrier has direct contracts with multiple payers how should this data be submitted?	This data is submitted along with all other claims data for group or individual accounts. In this instance the Vision Carrier provides the **Group or Policy Number in MC006 (Insured Group or Policy Number) of MC079 (Product ID Number)** that can be used to link the member to a specific medical carrier.

Dental Claims File

As part of the All Payer Claims Database (APCD) carriers are required to submit a Dental Claims File. The Division of Healthcare Finance and Policy (Division), in an effort to decrease any programming burden, has adopted a file layout currently in use by another state.

Below we have provided details on business rules, data definitions and the potential uses of this data.

Types of Data Collected in the Dental Claims File

Carrier-assigned Identifiers

The Division requires various Carrier-assigned identifiers for matching-logic to the other files, i.e., Product File, Member Eligibility. Examples of these fields include DC003, DC006, DC056 and DC057. These fields can be used to aid with the matching algorithm to those other files.

Claims Data

The Division requires the line-level detail of all Dental Claims for analysis. The line-level data aids with understanding utilization within products across Carriers. Subscriber and Member (Patient) Carrier unique identifiers can be used to aid with the **matching** algorithm; see DC056 and DC057.

Non-Massachusetts Resident

The Division will not require payers submitting claims and encounter data on behalf of an employer group to submit claims data for employees who reside outside of Massachusetts, unless the payer is required by contract with the Group Insurance Commission to submit paid claims and encounter data for all Massachusetts residents, and all members of a Massachusetts employer group including those who reside outside of Massachusetts.

Adjudication Data

The Division requires adjudication-centric data on the file for analysis of Member Eligibility to Product. The elements typically used in an adjudication process are DC017, DC030, DC031, DC037 through DC041, DC045, DC046 are variations of paper remittances or the HIPAA 835 4010.

Denied Claims

Payers are not required to submit wholly denied claims.

The Provider ID

Element DC018 (Provider ID) is one of the most critical fields in the APCD process as it links the Provider identified on the Dental Claims file with the corresponding record in the Provider File (PV002). The definition of PV002, Provider ID is:

> *The unique number for every service provider (persons, facilities or other entities involved in claims transactions) that a carrier has in its system. This field is used to uniquely identify a provider and that provider's affiliation and a provider and a provider's practice location within this provider file.*

The goal of PV002 is to help identify provider data elements associated with provider data that was submitted in the claim line detail, and to identify the details of the Provider Affiliation.

Dental Claims Release File Structure and FAQ:

<table>
<tr><th>Issue</th><th>Clarification</th></tr>
<tr><td>Frequency of submission</td><td>Dental claim files are to be submitted monthly

The Division requires this frequency to maintain a current dataset for analysis.</td></tr>
<tr><td>Release File Format</td><td>Release files will be in an asterisk-delimited text file.

Public Release File:

• Data Elements will be delimited in the order outlined in the File Layout section of this document.
• Any empty columns will be included in the specified order and will have no spaces or characters between the asterisks.

Restricted Release File:

• Only the requested and approved Data Elements will be included in the release file.

Released elements will be delimited in the same order as is found in the File Layout section of this document.</td></tr>
<tr><td>Rows</td><td>Each row in the APCD Dental Claims file represents one claim line.

If there are multiple services performed and billed on a claim, each of those services will be uniquely identified and reported on a line.

Line item data provides an understanding of how services are utilized and adjudicated by different carriers.</td></tr>
<tr><td>Redundancy</td><td>Certain data elements of claim level data are repeated in every row in order to report unique line item processing and maintain a link between line item processing and claim level data.</td></tr>
<tr><td>Changes to Claim Lines</td><td>Claim line Versioning is triggered by the Claim Line Type field:

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<tr><th>Claim Line Type Code</th><th>Claim Line Type Description</th><th>Action/Source</th></tr>
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<tr><td>Final Version flag</td><td>Final Version flag has been added to the APCD by DHCFP and will be included in the Public data release set for all Claims files.

• This flag indicates the highest version of a claim line. The flag is set as the final step of the Versioning process.
• Refer to the Versioning section of this document for more information.

As a result of changes submitted for claim lines, there may be several versions of a Claim Line in the database. The APCD data release will include all payer-submitted Claim Lines regardless of duplicates and Claim Line Type.

The Final Version flag indicates which Claim Lines should be included in the final version of a Claim, to the best of the ability of the Division’s current process. If the final version of a claim is a void, no flag is set.</td></tr>
</table>

Issue	Clarification
Claim ID	**Dental Claims** may be identified as follows: **Public data release:** • **Claim lines** may be **grouped** by the Combined Masked field for Payer/Member or Payer/Subscriber, but separate claims may not be identified as such. **Restricted data release:** • **Claims** may be isolated by grouping claim lines by the following elements: o DC004 Payer Claim Control Number (Restricted) o Payer Org Id DC001 (Restricted and Masked)
Denied claim lines	Wholly denied claims should not be reported at this time. However, if a **single procedure** is denied within a paid claim that denied line should be reported. Denied line items of an adjudicated claim aid with analysis in the APCD in terms of covered benefits and/or eligibility.
Claims that are paid under a '**global payment', or 'capitated payment',** thus zero paid	Any dental claim that is considered 'paid' by the carrier should appear in this filing. Paid amount should be reported as 0 and the corresponding Allowed, Contractual, Deductible Amounts should be calculated accordingly. The reporting of Zero Paid Dental Claims aids with the analysis of Member Eligibility as they apply to Dental Products.
Previously paid but now **Voided** claims	Claims that were paid and reported in one period and voided by either the Provider or the Carrier in a subsequent submission period are reported in this file. The reporting of Voided Claims maintains logic integrity between services utilized and deductibles applied.
The word **'Member'** is used in the specification. Are **'Member'** and '**Patient'** used synonymously?	Yes. **Member** and **Patient** are to be used in the same manner in this specification
Claims processed by a **third-party administrator:** who is responsible for submitting the data and how should the data be submitted?	In instances where more than one entity administers a health plan, **the health care carrier AND third-party administrators are responsible for submitting data** according to the specifications and format defined in the Submission Guides. This means that some records may be represented twice – once by the carrier, and once by the TPA. The Division's objective is to create a **comprehensive** All-Payer database which must include data from all health care carriers and third-party administrators. Future releases planned by the Division will consolidate duplicative eligibility and claims reporting to remove duplication and provide one set of the most complete and accurate data.

Dental Claims File FAQ	Response
Do dental carriers submit one Dental Claims file or multiple Dental Claims files?	Dental carriers submit one Dental Claims File for all of their members that are not linked to a direct contract with one of the medical carriers. This would include claims related to all group or individual policies a dental carrier would have in Massachusetts.
If a Dental Carrier has direct contracts with one or multiple	This data can be submitted along with all other claims data for group or individual accounts. In this instance

Dental Claims File FAQ	Response
payers how is this data submitted?	the Dental Carrier should provide the Group or Policy Number in DC006 (Insured Group or Policy Number) of DC042 (Product ID Number) that can be used to link the member to a specific medical carrier.
What other files and fields do Dental Carriers submit other than claims?	Dental Carriers submit a Member Eligibility, Provider and Product file. The Division understands that many of the fields in these files are more likely associated with medical carriers. In these instances, Dental carriers submit this information in the variance request. The variance will state a Proposed Threshold of 0% with all the other proper columns filled out. The Rationale Column of the variance request would indicate that the data elements requested are **not applicable** to a Dental Carrier. No variance request is necessary for the Medical and Pharmacy Files. The Organization Submitter ID (OrgID) indicates which files a carrier is required to submit.

Pharmacy Claims File

As part of the All Payer Claims Database (APCD) carriers will be required to submit a **Pharmacy Claims File**. Below we have provided details on business rules, data definitions and the potential uses of this data.

Types of Data Collected in the Pharmacy Claims File

Carrier-assigned Identifiers

The Division requires various Carrier-assigned identifiers for matching-logic to the other files, i.e., Product File, Member Eligibility. Some examples of these fields include PC003, PC006, PC107 and PC108. These fields can be used to aid with the matching algorithm to those other files.

Claims Data

The Division requires line-level detail of all Pharmacy Claims for analysis. The line-level data aids with understanding utilization within products across Carriers. Subscriber and Member (Patient) Carrier unique identifiers are included to aid with the matching algorithm, see PC107 and PC108.

Non-Massachusetts Resident

The Division will not require payers submitting claims and encounter data on behalf of an employer group to submit claims data for employees who reside outside of Massachusetts, unless the payer is required by contract with the Group Insurance Commission to submit paid claims and encounter data for all Massachusetts residents, and all members of a Massachusetts employer group including those who reside outside of Massachusetts.

Adjudication Data

The Division requires adjudication-centric data in order to comply with analytic requirements. The elements typically used in an adjudication process are PC017, PC025, PC036, PC040 through PC042, PC063, PC065 through PC070 and PC110.

Denied Claims

Payers are not required to submit wholly denied claims.

Provider Identifiers

The Division has made a conscious decision to collect numerous identifiers that may be associated with a provider. The identifiers will be used to help link providers across carriers in the event that the primary linking data elements are not a complete match. The existence of these extra identifying elements will improve the quality of our matching algorithms. Examples of these identifying elements include PC043-PC055 relating to the Prescribing Provider.

The Provider ID

Elements PC043 (Prescribing Provider ID) and PC048 (Prescribing Physician NPI) are critical fields which link the Prescribing Provider identified on the Pharmacy Claims file with the corresponding record in the Provider File (PV002). The definition of PV002, Provider ID, is:

The unique number for every service provider (persons, facilities or other entities involved in claims transactions) that a carrier has in its system. This field is used to uniquely identify a provider and that provider's affiliation and a provider and a provider's practice location within this provider file.

The goal of PV002, Provider ID, is to help identify provider data elements associated with provider data that was submitted in the claim line detail, and to identify the details of the Provider Affiliation.

Pharmacy Claims Release File Structure and FAQ:

<table>
<tr><th>Issue</th><th>Clarification</th></tr>
<tr><td>Frequency of submission</td><td>Pharmacy claim files are to be submitted monthly</td></tr>
<tr><td>Release File Format</td><td>Release files will be in an asterisk-delimited text file.

Public Release File:

• Data Elements will be delimited in the order outlined in the File Layout section of this document.
• Any empty columns will be included in the specified order and will have no spaces or characters between the asterisks.

Restricted Release File:

• Only the requested and approved Data Elements will be included in the release file.
• Released elements will be delimited in the same order as is found in the File Layout section of this document.</td></tr>
<tr><td>Changes to Claim Lines</td><td>Claim line Versioning is triggered by the Claim Line Type field:
<table>
<tr><th>Claim Line Type Code</th><th>Claim Line Type Description</th><th>Action/Source</th></tr>
<tr><td>O</td><td>Original</td><td></td></tr>
<tr><td>V</td><td>Void</td><td>Delete line referenced / Provider</td></tr>
<tr><td>R</td><td>Replacement</td><td>Replace line referenced / Provider</td></tr>
<tr><td>B</td><td>Back Out</td><td>Delete line referenced / Payer</td></tr>
<tr><td>A</td><td>Amendment</td><td>Replace line referenced / Payer</td></tr>
</table>
Refer to the Versioning section of this document for more information.</td></tr>
<tr><td>Final Version flag</td><td>Final Version flag has been added to the APCD by DHCFP and will be included in the Public data release set for all Claims files.

• This flag indicates the highest version of a claim line. The flag is set as the final step of the Versioning process.
• Refer to the Versioning section of this document for more information.

As a result of changes submitted for claim lines, there may be several versions of a Claim Line in the database. The APCD data release will include all payer-submitted Claim Lines regardless of duplicates and Claim Line Type.

The Final Version flag indicates which Claim Lines should be included in the final version of a Claim, to the best of the ability of the Division’s current process. If the final version of a claim is a void, no flag is set.</td></tr>
</table>

Issue	Clarification
Claim ID	**Pharmacy Claims** may be identified as follows: **Public data release:** • **Claim lines** may be **grouped** by the Combined Masked field for Payer/Member or Payer/Subscriber, but separate claims may not be identified as such. **Restricted data release:** • **Claims** may be isolated by grouping claim lines by the following elements: o PC004 Payer Claim Control Number (Restricted and Masked) o Payer Org Id PC001 (Restricted and Masked)
Rows	Each row represents a claim line, typically a prescription. It is necessary to obtain claim line item data to make sure each prescription is captured.
Denied Claim lines	Wholly denied claims should not be reported at this time. However, if a **single claim line** is denied within a paid claim that denied line should be reported. Denied line items of an adjudicated claim aid with utilization analysis.
Should previously paid but now Voided claims be reported?	Yes. Claims that were paid and reported in one period and voided by either the Provider or the Carrier in another submission period are reported in this file. The reporting of Voided Claims maintains logic integrity between services utilized and deductibles applied.
What types of claims are to be included?	The Pharmacy Claims file is used to report any pharmacy claim sent to and paid by the Carrier/PBM.
The word 'Member' is used in the specification. Are 'Member' and 'Patient' used synonymously?	Yes. Member and Patient are to be used in the same manner in this specification
If claims are processed by a third-party administrator, who is responsible for submitting the data and how should the data be submitted?	In instances where more than one entity administers a health plan, the health care carrier **and** third-party administrators are responsible for submitting data according to the specifications and format defined in the Submission Guides. This means that some records may be represented twice – once by the carrier, and once by the TPA. The Division's objective is to create a **comprehensive** All-Payer database which must include data from all health care carriers and third-party administrators. Future releases planned by the Division will consolidate duplicative eligibility and claims reporting to remove duplication and provide one set of the most complete and accurate data.

FAQ	Response
What files must a standalone	For standalone Pharmacy Carriers who offer either **direct benefits to Medicare Part D recipients**, **group accounts or individuals**, or **benefits via a contract with a medical carrier**, the Pharmacy Carrier submits claims using the **Pharmacy file format, along with a Member**

FAQ	Response
Pharmacy carrier submit?	**Eligibility and Product file.** Stand-alone pharmacy carriers are able to submit variance requests for data elements that they feel are not applicable to their business model. The variance should state a Proposed Threshold of 0% with all the other proper columns filled out. The Rationale in Column I of the variance request should indicate that the data elements requested are not applicable to a Standalone Pharmacy Carrier. **No variance request is necessary for the Medical, Dental and Provider files. The Organization Submitter ID (OrgID) will indicate which files a carrier is required to submit.**
Are Pharmacy Benefit Managers (PBMs) required to submit claims?	While most medical carriers are submitting the pharmacy claims sent from contracted PBMs each month, **PBMs are also required to resend those same claims to the Division**. **If the medical carriers do not receive pharmacy claims for self-insured medical accounts, PBMs are required to send the pharmacy claims to the Division**.

Provider File

As part of the All Payer Claims Database (APCD) carriers are required to submit a Provider file. This is a file type that has not been previously requested of carriers.

Below we have provided details on business rules, data definitions and the potential uses of this data.

Types of Data Collected in the Provider File

Provider Identifiers

The Division has made a conscious decision to collect numerous identifiers that may be associated with a provider. The data in fields PV002 through PV008, PV035, PV036, PV039, and PV040 (refer to the File Layout section of this document) can be used when analyzing provider data across carriers. The identifiers will be used to help link providers across carriers in the event that the primary linking data elements are not a complete match. The existence of these extra identifying elements will improve the quality of matching algorithms.

Demographics

The Division collects address information on each provider entity in order to meet reporting and analysis requirements. Additional demographic data elements such as Gender and Date of Birth for the provider are collected mainly for use in linking providers across carriers. These two fields can be used, when provided, to help with the quality of the matching algorithms across carriers.

Provider Specialty

The fields Taxonomy, Provider Type Code, and Provider Specialty (1-4) are required fields and can be used to meet reporting and analysis requirements including clinical groupings and provider specific reports. Each carrier submits its internal code sets (lookup tables) to the Division for these fields. Refer to the **Carrier-specific Information** section of this document.

Dates

The Division is collecting **two sets of date fields** for each provider record:

- **The Begin and End date for each provider** describes the dates the provider is active with the carrier and is eligible to provide services to members. For providers who are still active the End date should be Null**.**
- **The Provider Affiliation Start and Provider Affiliation End Date** describe the providers' affiliation/association with a parent entity, such as a billing entity, corporate entity, doctor's office, provider group, or integrated delivery system. Each unique instance of these start and end dates should be submitted as a separate record on this file. If a provider was active and termed in the past with the carrier, and was added back as an active provider, each instance of those 'active' dates should be provided, one for each time span. Similarly, each instance of a provider affiliation, and those associated dates should be provided in a record. If a provider has always been active with a carrier since 2008, but has changed affiliations once, there would be two records submitted as well, one for each affiliation and those respective dates. If a provider's affiliation is terminated, and is made active again at a later date, this would require two records as well.

Qualifiers

The Division collects provider information related to **healthcare reform**, **electronic medical records**, and **patient centered medical home**. These data elements may or may not currently be captured in carrier's core systems. These elements will inform more in depth analysis as this data becomes more common in the industry. The thresholds for these fields are lower in the short term to allow providers and carriers more time to capture and submit this information.

Examples:

1. **Individual Provider practicing within one doctor's office or group and only one physical office location.**
   A provider fitting this description should have 1 record per active time span. The record would contain information about the provider (Dr. Jones) and the affiliation fields would indicate that Dr. Jones practices or contracts with (ABC Medical). ABC Medical, since it is a group, would have its own separate record as well in this file. A physician assistant or nurse working in the doctor's office should also be submitted, under their own unique record.

2. **Individual Provider practicing within an office they own.**
   A provider fitting this description should have 1 record per active time span for their individual information (Dr. Jones) and a second record for their practice, Dr. Jones Family Care. A physician assistant or nurse working in the doctor's office should also be submitted, under their own unique record.

3. **Individual Provider practicing within an office they own or for a practice they do not own across two physical locations**.
   A provider fitting this description should have 2 records per active time span. The office, affiliation or entity that the doctor does business under (ABC Medical, Dr. Jones family medicine) would have only 1 additional record.

4. **Individual Provider practicing across two groups or different affiliations.**
   A provider fitting this description should have 2 records per active time span, one for each group/entity they are affiliated with. Each group/entity would have its own separate record as well.

5. **Entity, Group or Office in one location**
   An entity fitting this description should have one record per active time span. All affiliated entities, or providers that could be linked or rolled up to these entities, groups or offices, would each have their own records.

6. **Entity, Group or Office in two locations**
   An entity fitting this description should have two records per active time span, one for each location. All affiliated entities, or providers that could be linked or rolled up to these entities, groups or offices, would each have their own records. If these affiliated entities and providers are associated with just one of the locations, they would have one corresponding record. If they are affiliated with each of the parent entity's locations, they should have one record for each location, similar to example 3.

7. **Billing organizations**
   An entity that shows up in the claims file in the Billing Provider field should also have a corresponding provider record. Medical Billing Associates, Inc. should have one record for each location and identifier it bills under as determined by the claims file.

8. **Integrated Delivery Systems**
   Organizations such as Partners Healthcare or Atrius Health should have their own record if the carrier has a contract with those entities. All entities, groups or providers affiliated with the Organization should have the Provider ID of this entity in the Provider Affiliation Field. Entities meeting a description similar to an Integrated Delivery System should show up one time in the provider file.

The Provider ID

Field, PV002, Provider ID is one of the most critical fields in the Provider File. The definition of this field is:

This field contains the unique number for every service provider (persons, facilities or other entities involved in claims transactions) that a carrier has in its system. This field is used to uniquely identify a provider and that provider's affiliation and a provider and a provider's practice location within this provider file.

- The goal of this field is to help identify provider data elements associated with provider data that was submitted in the claim line detail, and to identify the details of the Provider Affiliation.
- A Provider ID itself may or may not be unique on this file – but in combination with the Provider Affiliation (PV056) – the two together must be unique **for a given time period.**

- Loading a record where PV002 = PV056 establishes a base record for a provider. All other instances of that PV002 value represent affiliations or additional locations for a provider. See the "ProviderFile Examples.xls" document on the DHCFP website for sample data.

Provider Release File Structure and FAQ:

Issue	Clarification
Frequency of submission	Monthly
Release File Format	Release files will be in an **asterisk-delimited text file**. **Public Release File:** • Data Elements will be delimited in the order outlined in the File Layout section of this document. • Any empty columns will be included in the specified order and will have no spaces or characters between the asterisks. **Restricted Release File:** • Only the requested and approved Data Elements will be included in the release file. • Released elements will be delimited in the same order as is found in the File Layout section of this document.
Rows	Each row represents a unique instance of **a provider entity**, and: • that provider's **affiliation to another entity**, or • a provider's **affiliation to a specific location** This information can be used to analyze data on providers, clinicians, hospitals, physician groups and integrated delivery systems.
Provider, as defined by the Division	A Provider is an entity or person associated with either: 1. providing services to patients 2. submitting claims for services on behalf of a servicing provider 3. providing business services or contracting arrangements for a servicing provider A Provider may be a **health care practitioner**, **health care facility**, **health care group**, **medical product vendor**, or **pharmacy**.
Unique Provider Record, defined	Conceptually, a unique provider is an instance of a **provider (Who),** with a particular **affiliation (Relationship),** at a particular **location (where),** during a **pre-defined timeframe (when)**. Carriers store their provider data in a variety of formats and data structures. The Division feels this methodology will provide the most flexibility to analyze provider data.

<table>
<tr><th>Issue</th><th>Clarification</th></tr>
<tr><td>Types of providers included in the file</td><td>All Massachusetts contracted providers, regardless of whether they are on the claims file for the time period. Additionally, provider information for out of state providers, who are on the claims file for the time period of the corresponding claims submission – If available. Otherwise default values are used in the Medical Claims file, as provided below.

The codes below represent valid acceptable values for provider references (used in the Medical Claims file) that do not exist in the Carrier Provider database.

<table>
<tr><td>HCF-99901</td><td>Unknown Out of State Physician</td></tr>
<tr><td>HCF-99902</td><td>Unknown - Out of State Facility</td></tr>
<tr><td>HCF-99903</td><td>Unknown - Out of State Professional Group</td></tr>
<tr><td>HCF-99904</td><td>Unknown - Out of State Retail Site</td></tr>
<tr><td>HCF-99905</td><td>Unknown - E-Site (Services provided over the Internet)</td></tr>
<tr><td>HCF-99907</td><td>Unknown - Other Provider</td></tr>
<tr><td>HCF-99908</td><td>Member Reimbursement Payment</td></tr>
<tr><td>HCF-99909</td><td>Not Applicable - Patient Home Care</td></tr>
</table>
These values (as specified in the <u>ProviderFile Examples.xls</u> document on the APCD website) can be used in fields MC024 (Service Provider ID), MC134 (Plan Rendering Provider) and MC135 (Provider Location). In this scenario the carrier would not put a corresponding record in the Provider File. This code indicates that the carrier information is not available because the carrier is out of state.

In order to create a cross-carrier provider file for analysis, the Division requires data on all providers in a carrier's Massachusetts network. Additionally, all claims may be analyzed by provider dimensions that require provider information for corresponding out of state claims.</td></tr>
<tr><td>Reporting time period, and providers to be included on the file</td><td>All providers, both active and non-active. Providers who have not been active since January 2008 do not need to be included.

The Division's intention is to collect the most up to date provider data that can be used to analyze claims data. Since claims data is collected monthly, the provider file can be synced with the claims file, and can be a snapshot of how the provider file looked at the end of the period for which claims are sent.</td></tr>
</table>

Provider File FAQ	Response
Are carriers required to submit **provider information for pharmacies** in the Provider File?	If the pharmacy is delivering a **medical service such as a flu shot, minute clinic services, or other**, the pharmacy would be noted as the servicing provider in the Medical Claims File (MC024) and needs to be in the Provider File. If the pharmacy is only dispensing the prescriptions they should not be in the provider file. Pharmacy information is required in the Pharmacy File, specifically fields PC018 through PC024a.
Should the Provider File include records for those **providers who do not have claims?**	**Yes,** the Provider File should include all Massachusetts providers a carrier is contract with and/or has a record of claims.
Do carriers need to submit data for Massachusetts contracted/par/**in network providers who are not found as a servicing provider** on the claims file?	Yes, this is a requirement.

Provider File FAQ	Response
Do carriers need to submit data for Massachusetts non-contracted/non-par/**out of network providers who are not found as a servicing provider** on the claims file?	No, this information is not required to be submitted; however, if this data is already in a carrier's provider database the Division accepts this data.
Do medical carriers need to submit provider records for **behavioral health, vision or dental providers**, if they contract with a separate carrier for these services?	If the medical carrier has these providers in their system they should be submitted. The provider information from the contracted delegated vendors (dental, vision and behavioral health carriers) may differ from the information the medical carrier has.
Please explain the definition of, and the goal of capturing **PV058, 'Delegated Provider Flag'**?	This field indicates whether the provider record was sourced from the carrier's provider data system or from a delegated vendor, such as a behavioral health or dental carve out vendor that the carrier contracts with. This field indicates a reason for differences in the consistency, completeness and quality of data in the provider file. Carriers have told the Division that the delegated vendors' provider data may not be as complete and may be structured differently than their own internally contracted provider's data. A value of '1' tells the Division that the data came from an external vendor. In this case, the Division understands that the data was not sourced from the Carrier's internal systems, and relaxes the thresholds and edits for those provider records.

FILE LAYOUT

APCD Data Elements are eligible for either **Public Release** or **Restricted Release**, or are **not available** for release. Applications are required for purchase of data, and must be approved by the Division for either Public or Restricted data elements. The APCD Data Application is on the **DHCFP website.**

The following sections list **all APCD data elements**, grouped by file type and then by level of availability for release.

Public Release and Restricted Release data elements are released in separate files. Release files will be in an **asterisk-delimited text file**.

Public Release File:

- **Public Release** files are structured as described in the sections listed below.
- Each **row** in the release file contains one record of the indicated file type. There is an **asterisk-delimited field** in each row for every data element listed in the Public Release sections for each file type.
- Data Elements will be delimited in the order displayed in the Public Release File Layout sections of this document.
- Any empty fields will be included in the row, in the specified order; **empty** or **null** data elements will have no spaces or characters between the asterisks.

Restricted Release File:

- To request **Restricted Data Elements**, applicants must check the requested data elements on the application form, and explain why access is needed to EACH Restricted Use data element for the project. **Release is limited to the minimum number of Restricted Release data elements necessary to complete the project**. The Restricted Release files for each file type will contain **only the elements approved for release**.
- Each row will contain the approved restricted elements for one record of the indicated file type. Unique row IDs provide a link to the Public data elements for the same record.

Lookup Tables:

- **Element-specific** Lookup Tables are included in this document after each File Type Layout section.
- A **Carrier-Specific Master Lookup** table is included with the Data Release. Refer to the **Carrier-Specific Reference** and **Linking** sections in this document for more information.
- **External Code Sources** are listed in Appendix 2 of this document.

Masked Elements:

- For the Data Release, some of the **Masked** APCD data elements have been **Combined and Masked**, to protect confidentiality for Payers and Providers, and individuals, while allowing for linkage between claims, files, and lookup tables. Refer to the **Data Protection/Confidentiality** and **Linkage** sections of this document for more information.

File Layout Section Columns

- **Order:** The order in which the elements are laid out in the Release text file rows.
- **Element**: The code name of the element, with reference to the Regulation and the Submission files received by the Division from Payers. The first two digits refer to the File Type and the following numbers to the ordering in the Submission Files.
- **Data Element Name:** Name of the element.
- **Max Length:** Maximum Length of the data column in the APCD's SQL Server database at the Division.
- **Data Type Guide:** Data Type of the column in the APCD's SQL Server database at the Division. When the APCD Release text file is imported to a database or other file type by the final user of the data, these data types provide a guide to setting up the columns in the receiving file.
- **Description:** Description of the element.
- **Release Notes:** Additional information about the element in the release.
- **Edit Level:** Level of enforcement of the data element's requirements by the Division on Payer Submissions. Refer to the **Edits** section of this document.
- **APCD Threshold:** The expected percentage of validity for instances of the element in each submission file by the Payer
- **Public/Restricted:** Indicates if the element is available for Public or Restricted release.
- **Masked:** Indicates the field contents of the data element are Masked in the release.

Release Text File Column Titles

- **Appendix 3: Release File Column Names** included in this document lists the column name for each data element in the Public and Restricted release files. The text files exported from the APCD SQL Database include these SQL column names in the first row.

The APCD Product File

Product File - Public Use Data Elements										
Order	**Element**	**Data Element Name**	**Max Length**	**Data Type Guide**	**Description**	**Release Notes**	**Edit Level**	**APCD Threshold**	**Public / Restricted**	**Masked**
1	PR006	Product Benefit Type	1	varchar	Indicates combinations of offerings (Lookup Table)	Numeric indicator that reports a benefit selection or a product-range offering as defined by the carrier or its designee.	A0	100%	P	No
2	PR008	Risk Type	1	varchar	Indicates if the product was an at-risk product or self-insured. (Lookup Table)	Numeric indicator that reports the product development attribute that defines a risk assignment.	A2	100%	P	No
3	PR011	Product Active Flag	1	varchar	Indicator to further refine activity status (Lookup Table)	Numeric indicator that reports active vs. inactive products for the date span indicated in Product Start and End Dates.	C	100%	P	No
4	PR012	Annual Per Person Deductible Code	3	varchar	Per Person Deductible bandwidth reporting (Lookup Table)	Value that represents the Total Per Person Deductible for all benefits under this product for the date span indicated in Product Start and End Dates.	B	100%	P	No
5	PR013	Annual Per Family Deductible Code	3	varchar	Per Family Deductible bandwidth reporting (Lookup Table)	Value that represents the Total Per Family Deductible for all benefits under this product for the date span indicated in Product Start and End Dates	B	100%	P	No
6	PR014	Coordinated Care model	1	varchar	Indicates if a patient's care is clinically coordinated or managed. (Lookup Table)	Numeric indicator that reports if Patient care is clinically coordinated or managed, as an attribute of this product, by the carrier or its designee	C	100%	P	No
7	PR899	Record Type	2	varchar	File Type Identifier	The APCD filing-type identifier that defines the data contained within the file.	A0	100%	P	No
8	HD002/ PR001	Payer / Product ID	256	varbinary	Header Submitter Org ID as defined by DHCFP / Carrier assigned Product Identification Number	Combined Payer/Product ID for de-identified linking to Eligibility and Claims data. Masked value. Can be linked to masked value in elements with the same combined ID values.			P	Yes
9	Derived by DHCFP	Unique Record ID: Public File	10	int	Unique Record ID - Derived by DHCFP	Unique Record ID for Product record: Restricted File value matches Public File value for the same record.			P	No

Product File - Restricted Use Data Elements										
Order	**Element**	**Data Element Name**	**Max Length**	**Data Type Guide**	**Description**	**Release Notes**	**Edit Level**	**APCD Threshold**	**Public / Restricted**	**Masked**
1	PR001	Product ID	256	varbinary	Product Identification Number	Carrier-assigned identifier that uniquely defines this Product. This identifier is used in tandem with Payer Org ID to align Products to Eligibility and the corresponding claims when applicable.	A0	100%	R	Yes
2	HD002	Payer	256	varbinary	Carrier/Submitter Org ID (from the file Header)	Unique identifier assigned by the Division of Health Care Finance & Policy to each Carrier/Submitter	A0	100%	R	Yes
3	PR002	Product Name	256	varbinary	Carrier defined Product Name	Unique name assigned to Product by Carrier/Submitter	C	100%	R	Yes
4	PR003	Carrier License Type	256	varbinary	Carrier License Type (Lookup Table – Redacted due to identifying data)	A code that defines the license type associated with the Product filing with the Massachusetts Division of Insurance.	A0	100%	R	Yes
5	PR004	Product Line of Business Model	2	varchar	The Line of Business / Insurance Model the Product relates to. (Lookup Table)	A code that defines a product's business model as defined by the carrier or its designee. Value of ZZ (Other) should correspond to non-insurance vendors; Claim Re-processors or Re-pricers, Computer Leasing, etc.	A0	100%	R	No
6	PR005	Insurance Plan Market	10	varchar	Insurance Plan Market Code (Lookup Table)	A code that defines a product's business model as defined by the carrier or its designee. Value of ZZ (Other) should correspond to non-insurance vendors; Claim Re-processors or Re-pricers; Computer Leasing; etc.	A0	100%	R	No
7	PR007	Other Product Benefit Description	256	varbinary	Benefit Description	Refining description applied by carrier or its designee when PR006 was reported as 0 (Other).	B	100%	R	Yes
8	PR009	Product Start Date	23	datetime	Product Start Date	First date that a product is eligible for Member enrollment. (YYYY-MM-DD 00:00:00.000)	A0	100%	R	No
9	PR010	Product End Date	23	datetime	Last date on which members could be enrolled in this product	Last date that product is active for Member enrollment. (YYYY-MM-DD 00:00:00.000)	B	100%	R	No

Product File - Restricted Use Data Elements										
Order	**Element**	**Data Element Name**	**Max Length**	**Data Type Guide**	**Description**	**Release Notes**	**Edit Level**	**APCD Threshold**	**Public / Restricted**	**Masked**
10	Derived by DHCFP	Unique Record ID: Restricted File	10	int	Unique Record ID - Derived by DHCFP	Unique Record ID for Product record: Restricted File value matches Public File value for the same record.			R	No

APCD Product File Lookup Tables, by Element										
Order	**Element**	**Data Element Name**	**Max Length**	**Data Type Guide**	**Description**	**Release Notes**	**Edit Level**	**APCD Threshold**	**Public / Restricted**	**Masked**
5	PR004	Product Line of Business Model	2	varchar	The Line of Business / Insurance Model the Product relates to. (Lookup Table)	A code that defines a product's business model as defined by the carrier or its designee. Value of ZZ (Other) should correspond to non-insurance vendors; Claim Re-processors or Re-pricers, Computer Leasing, etc.	A0	100%	R	No
					Product Line Of Business Model Code	***Product Line Of Business Model***				
					12	Preferred Provider Organization (PPO)				
					13	Point of Service (POS)				
					14	Exclusive Provider Organization (EPO)				
					15	Indemnity Insurance				
					16	Health Maintenance Organization (HMO) Medicare Advantage				
					AC	Accident Only				
					BH	Basic Hospital				
					CH	CHAMPUS				
					DM	Dental Maintenance Organization				
					DS	Disability				
					HC	HMO - Closed				

APCD Product File Lookup Tables, by Element										
Ord-er	**Element**	**Data Element Name**	**Max Length**	**Data Type Guide**	**Description**	**Release Notes**	**Edit Level**	**APCD Thres-hold**	**Public / Restrict -ed**	**Masked**
					HO	HMO - Open				
					IN	Individual				
					LM	Liability Medical				
					MC	Medicaid FFS				
					MO	Medicaid Managed Care Organization				
					MP	Medicare Primary				
					MR	Medicare				
					OF	Other Federal Program (e.g. Black Lung)				
					PC	Medicaid Primary Care Clinician Plan				
					PR	Preferred Provider Organization (PPO)				
					QM	Qualified Medicare Beneficiary/SLMB				
					SA	Self-Administered Group				
					SC	Senior Care Option				
					SP	Supplemental Policy				
					TV	Title V				
					VA	Veterans Administration Plan				
					WC	Workers' Compensation				
					ZZ	Mutually Defined Other				

APCD Product File Lookup Tables, by Element										
Order	**Element**	**Data Element Name**	**Max Length**	**Data Type Guide**	**Description**	**Release Notes**	**Edit Level**	**APCD Threshold**	**Public / Restricted**	**Masked**
6	PR005	Insurance Plan Market	10	varchar	Insurance Plan Market Code (Lookup Table)	A code that defines a product's business model as defined by the carrier or its designee. Value of ZZ (Other) should correspond to non-insurance vendors; Claim Re-processors or Re-pricers; Computer Leasing; etc.	A0	100%	R	No
					Insurance Plan Market Code	***Insurance Plan Market***				
					GPOS	Group - POS				
					GCOB	Group COBRA				
					GCCH	Group-Commonwealth Choice				
					GEMP	Group-Employer				
					GFED	Group-Federal				
					GGIC	Group-GIC				
					GMMK	Group-Merged Market				
					GMUN	Group-Municipality				
					GPRT	Group-Retiree				
					GSC0	Group-Senior Care Option				
					GUNN	Group-Union				
					HEXC	Health Exchange				
					ICCA	Individual - Commonwealth Care				
					ICCH	Individual - Commonwealth Choice				
					ICLO	Individual Closed				
					ICOB	Individual COBRA				
					IYGA	Individual Young Adult				
					MCRA	Medicare Part A				
					MCRB	Medicare Part B				

APCD Product File Lookup Tables, by Element										
Ord-er	**Element**	**Data Element Name**	**Max Length**	**Data Type Guide**	**Description**	**Release Notes**	**Edit Level**	**APCD Thres-hold**	**Public / Restrict -ed**	**Masked**
					MCRC	Medicare Part C				
					MCRD	Medicare Part D				
					MEDX	MediGap/Medicare Supplemental/Medex				
					ITHR	Other				
					OTMC	Other Medicare				
					STUD	Student				
					COBR	COBRA				
					GRUP	Group				
1	PR006	Product Benefit Type	1	varchar	Indicates combinations of offerings (Lookup Table)	Numeric indicator that reports a benefit selection or a product-range offering as defined by the carrier or its designee.	A0	100%	P	No
					Product Benefit Type Code	***Product Benefit Type***				
					1	Medical Only				
					2	Pharmacy Only				
					3	Medical and Pharmacy bundled				
					4	Dental				
					5	Behavioral Health				
					6	Vision				
					7	Accident Only				
					8	Medical Comprehensive				
					0	Other				

APCD Product File Lookup Tables, by Element										
Order	**Element**	**Data Element Name**	**Max Length**	**Data Type Guide**	**Description**	**Release Notes**	**Edit Level**	**APCD Threshold**	**Public / Restricted**	**Masked**
2	PR008	Risk Type	1	varchar	Indicates if the product was an at-risk product or self-insured. (Lookup Table)	Numeric indicator that reports the product development attribute that defines a risk assignment.	A2	100%	P	No
					Risk Type Code	***Risk Type Description***				
					1	Fully Insured				
					2	Self-Insured				
					3	Product available to risk and self-insured accounts				
3	PR011	Product Active Flag	1	varchar	Indicator to further refine activity status (Lookup Table)	Numeric indicator that reports active vs. inactive products for the date span indicated in Product Start and End Dates.	C	100%	P	No
					Value	***Description***				
					1	Yes				
					2	No				
					3	Unknown				
					4	Other				
					5	Not Applicable				
4	PR012	Annual Per Person Deductible Code	3	varchar	Per Person Deductible bandwidth reporting (Lookup Table)	Value that represents the Total Per Person Deductible for all benefits under this product for the date span indicated in Product Start and End Dates.	B	100%	P	No
					Annual Per Person Deductible Code	***Annual Per Person Deductible***				
					000	plans with no per person deductible				
					001	plans with per person deductibles under $1,000				
					002	plans with per person deductibles of $1,000 - $1,999				

APCD Product File Lookup Tables, by Element										
Ord-er	**Element**	**Data Element Name**	**Max Length**	**Data Type Guide**	**Description**	**Release Notes**	**Edit Level**	**APCD Thres-hold**	**Public / Restrict -ed**	**Masked**
					003	plans with per person deductibles $2,000-$2,999				
					004	plans with per person deductibles >= $3000				
					999	Not Applicable				
5	PR013	Annual Per Family Deductible Code	3	varchar	Per Family Deductible bandwidth reporting (Lookup Table)	Value that represents the Total Per Family Deductible for all benefits under this product for the date span indicated in Product Start and End Dates	B	100%	P	No
					Annual Per Family Deductible Code	**Annual Per Family Deductible**				
					000	plans with no per family deductible				
					001	plans with per family deductibles under $1,000				
					002	plans with per family deductibles of $1,000 - $1,999				
					003	plans with per family deductibles $2,000 - $2,999				
					004	plans with per family deductibles $3,000 - $3,999				
					005	plans with per family deductibles $4,000 - $4,999				
					006	plans with per family deductibles $5,000 - $5,999				
					007	plans with per family deductibles >= $6,000				
					999	Not Applicable				

APCD Product File Lookup Tables, by Element										
Ord-er	**Element**	**Data Element Name**	**Max Length**	**Data Type Guide**	**Description**	**Release Notes**	**Edit Level**	**APCD Thres-hold**	**Public / Restrict -ed**	**Masked**
6	PR014	Coordinated Care model	1	varchar	Indicates if a patient's care is clinically coordinated or managed. (Lookup Table)	Numeric indicator that reports if Patient care is clinically coordinated or managed, as an attribute of this product, by the carrier or its designee	C	100%	P	No
					Value	***Description***				
					1	Yes				
					2	No				
					3	Unknown				
					4	Other				
					5	Not Applicable				

APCD Product File: External Code Sources

Refer to Appendix 2 in this document: External Code Sources

The APCD Member Eligibility File

Member Eligibility File - Public Use Data Elements										
Order	**Element**	**Data Element Name**	**Max Length**	**Data Type Guide**	**Description**	**Release Notes**	**Edit Level**	**APCD Threshold**	**Public / Restricted**	**Masked**
1	ME003	Insurance Type Code/Product	2	varchar	Type / Product Identification Code (Lookup Table)	A code that defines the type of insurance applied to this eligibility segment by the carrier or its designee.	A1	96%	P	No
2	ME007	Coverage Level Code	3	varchar	Benefit Coverage Level Code (Lookup Table)	A code that reports relationships which are covered under the benefits during the time-period of this eligibility segment.	A1	99%	P	No
3	ME013	Member Gender	1	varchar	The Member's Gender (Lookup Table)	A code that defines the Member's gender.	A0	100%	P	No
4	ME014/ Year	Member Birth Year	10	int	Member Birth Year / Derived by DHCFP	Year of the Date of Birth of the Member. Member Birth Year is reported as "999" when the Member is age 90 or older as of the Product Enrollment Start Date.			P	No
5	ME016	Member State or Province	2	varchar	State of the Member (External Code Source 2)	State of the Member.	A0	99%	P	No
6	ME018	Medical Coverage	1	varchar	Indicator to refine Product or define Benefit within a Product. (Lookup Table)	Numeric indicator that reports if the Member has medical coverage as a benefit during the time-period of this eligibility segment.	A0	100%	P	No
7	ME019	Prescription Drug Coverage	1	varchar	Indicator to refine Product or define Benefit within a Product. (Lookup Table)	Numeric indicator that reports if the Member has prescription drug coverage as a benefit during the time-period of this eligibility segment.	A0	100%	P	No
8	ME020	Dental Coverage	1	varchar	Indicator to refine Product or define Benefit within a Product. (Lookup Table)	Numeric indicator that reports if the Member has dental coverage as a benefit during the time-period of this eligibility segment.	A0	100%	P	No

Member Eligibility File - Public Use Data Elements										
Order	**Element**	**Data Element Name**	**Max Length**	**Data Type Guide**	**Description**	**Release Notes**	**Edit Level**	**APCD Threshold**	**Public / Restricted**	**Masked**
9	ME021	Race 1	6	varchar	Member's self-disclosed Primary Race (Lookup Table)	A code that reports the self-disclosed primary race of the Member. A value of R9 (Other Race) requires narrative of this race in Other Race.	B	3%	P	No
10	ME022	Race 2	6	varchar	Member's self-disclosed Secondary Race (Lookup Table)	A code that reports the self-disclosed secondary race of the Member. A value of R9 (Other Race) requires narrative of this race in Other Race.	C	2%	P	No
11	ME023	Other Race	15	varchar	Member's self-disclosed Other Race (Free Text Field)	Definition of Other Race when UNKNOW is selected in either Race 1 or Race 2 elements.	C	99%	P	No
12	ME024	Hispanic Indicator	1	varchar	Indicator to define Hispanic status (Lookup Table)	Numeric indicator that reports if the Member has self-disclosed Hispanic heritage during the time-period of this eligibility segment.	B	3%	P	No
13	ME025	Ethnicity 1	6	varchar	Member's self-disclosed Primary Ethnicity (Lookup Table)	A code that reports the self-disclosed primary ethnicity of the Member. A value of OTHER requires narrative of this ethnicity in Other Ethnicity.	B	3%	P	No
14	ME026	Ethnicity 2	6	varchar	Member's self-disclosed Secondary Ethnicity (Lookup Table)	A code that reports the self-disclosed primary ethnicity of the Member. A value of OTHER requires narrative of this ethnicity in Other Ethnicity.	C	2%	P	No
15	ME027	Other Ethnicity	20	varchar	Member's self-disclosed Other Ethnicity	Definition of Other Ethnicity when UNKNOW is selected in either Ethnicity 1 or Ethnicity 2 elements.	C	99%	P	No
16	ME028	Primary Insurance Indicator	1	varchar	Indicator to define if Insurance is Primary (Lookup Table)	Numeric indicator that reports if the Member's eligibility is for primary insurance during the time-period of this eligibility segment.	A0	80%	P	No
17	ME029	Coverage Type	3	varchar	Type of Coverage Code (Lookup Table)	A code that reports the risk-type of the carrier the Member is covered under during the time-period stated on this eligibility segment.	A0	90%	P	No

Member Eligibility File - Public Use Data Elements										
Order	**Element**	**Data Element Name**	**Max Length**	**Data Type Guide**	**Description**	**Release Notes**	**Edit Level**	**APCD Threshold**	**Public / Restricted**	**Masked**
18	ME030	Market Category Code	4	varchar	Market Category Code (Lookup Table)	A code that reports the market the policy is sold into by the carrier or its designee during the time-period of this eligibility segment. Use this code to map to individuals and group sizes.	A0	95%	P	No
19	ME033	Member language preference	3	varchar	Member's self-disclosed verbal language preference (Lookup Table)	A code that reports the self-disclosed verbal language preference of the Member. A value of 708, 799 or 997 requires narrative of this language preference in Other Member Language Preference.	B	3%	P	No
20	ME034	Member language preference - Other	20	varchar	Member's self-disclosed verbal language secondary preference (free text)	Definition of Other Language Preference when 708, 799 or 997 is selected in Member Language Preference.	C	99%	P	No
21	ME035	Health Care Home Assigned Flag	1	varchar	Health Care Home Assigned indicator (Lookup Table)	Numeric indicator that reports if the Member has been assigned to a Health Care Home by the carrier or its designee during the time-period of this eligibility segment.	B	20%	P	No
22	ME037	Health Care Home Tax ID Number	256	varbinary	Health Care Home EIN	Tax ID of the Health Care Home.	C	90%	P	Yes
23	ME038	Health Care Home National Provider ID	256	varbinary	National Provider Identification (NPI) of the Health Care Home Provider (External Code Source 4)	The National Provider ID (NPI) of the Health Care Home.	C	10%	P	Yes
24	ME039	Health Care Home Name	256	varbinary	Name of Health Care Home	Name of the Health Care Home that the Member is assigned to during the time-period of this eligibility segment.	C	90%	P	Yes
25	ME047	Member PCP Effective Date	23	datetime	PCP Effective Date with Member	The date that the Member commenced an affiliation with the PCP reported in this eligibility segment. (YYYY-MM-DD 00:00:00.000)	B	98%	P	No

Member Eligibility File - Public Use Data Elements										
Order	**Element**	**Data Element Name**	**Max Length**	**Data Type Guide**	**Description**	**Release Notes**	**Edit Level**	**APCD Threshold**	**Public / Restricted**	**Masked**
26	ME048	Member PCP Termination Date	23	datetime	PCP Termination Date with Member	The date that the Member terminated affiliation with the PCP reported in this eligibility segment. (YYYY-MM-DD 00:00:00.000)	B	98%	P	No
27	ME049	Member Deductible	19	money	Annual maximum out-of-pocket Member Deductible across all benefit types	Value representing the Member's maximum annual out-of-pocket deductible, across all benefit types, (Medical, Rx, Vision, Behavioral Health, etc.) before certain services are covered. Only In-Network Deductibles are expected here.	A2	90%	P	No
28	ME050	Member Deductible Used	19	money	Member deductible amount incurred	Value representing the amount the Member has incurred to-date toward the maximum In-Network deductible across all benefit types (Medical, Rx, Vision, Behavioral Health, etc.).	B	0%	P	No
29	ME051	Behavioral Health Benefit Flag	1	varchar	Indicates if Behavioral / Mental Health is a covered benefit in the member's eligibility (Lookup Table)	Numeric indicator that reports if the Member has behavioral health coverage as a benefit during the time-period of this eligibility segment.	B	100%	P	No
30	ME052	Laboratory Benefit Flag	1	varchar	Laboratory Benefits indicator (Lookup Table)	Numeric indicator that reports if the Member has laboratory coverage as a benefit during the time-period of this eligibility segment.	B	100%	P	No
31	ME053	Disease Management Enrollee Flag	1	varchar	Chronic Illness Management indicator (Lookup Table)	Numeric indicator that reports if the carrier, or its designee, is managing the Member's chronic illness during the time-period of this eligibility segment.	B	100%	P	No
32	ME059	Disability Indicator Flag	1	varchar	Disability Identifier (Lookup Table)	Numeric indicator that reports if the Member is on Disability during the time-period of this eligibility segment.	C	100%	P	No
33	ME061	Student Status	1	varchar	Student Status Indicator (Lookup Table)	Numeric indicator that reports if the Member is a student during the time-period stated on this eligibility segment.	A0	100%	P	No

Member Eligibility File - Public Use Data Elements										
Order	**Element**	**Data Element Name**	**Max Length**	**Data Type Guide**	**Description**	**Release Notes**	**Edit Level**	**APCD Threshold**	**Public / Restricted**	**Masked**
34	ME062	Marital Status	1	varchar	Marital Status Code (Lookup Table)	A code that reports the marital status of the Member during the time-period of this eligibility segment.	B	100%	P	No
35	ME063	Benefit Status	1	varchar	Benefit Status Code (Lookup Table)	A code that reports the benefit status of the Member during the time-period of this eligibility segment.	B	100%	P	No
36	ME064	Employee Type	1	varchar	Employee Type Code (Lookup Table)	A code that reports the employee's employment type during the time-period of this eligibility segment.	C	100%	P	No
37	ME066	COBRA Status	1	varchar	COBRA usage indicator (Lookup Table)	Numeric indicator that reports if the Member is covered under COBRA during the time-period of this eligibility segment.	B	80%	P	No
38	ME073	Fully insured member	1	varchar	Fully Insured identifier (Lookup Table)	Numeric indicator that reports if the Member is Fully Insured during the time-period of this eligibility segment.	A0	100%	P	No
39	ME074	Interpreter	1	varchar	Interpreter Required indicator (Lookup Table)	Numeric indicator that reports if the Member has self-disclosed a need for an interpreter during the time-period stated on this eligibility segment.	C	0%	P	No
40	ME077	Members SIC Code	256	varbinary	Member Standard SIC Code (External Code Source 15)	Codes describing the line of work of the enrollee. Carriers will use standard SIC code values.	C	2%	P	Yes
41	ME081	Medicare Code	1	varchar	Medicare Plan Indicator Code (Lookup Table)	Numeric indicator that reports the Medicare coverage level, if any, of the Member during the time-period of this eligibility segment.	B	100%	P	No
42	ME109	Subscriber State or Province	2	varchar	State of the Subscriber	State of the Subscriber.	A0	99%	P	No
43	ME111	Medical Deductible	19	money	Maximum out of pocket amount of applied member's deductible	Value representing the maximum amount of the Member’s deductible that is applied to medical services before certain medical services are covered.	B	90%	P	No

Member Eligibility File - Public Use Data Elements										
Order	**Element**	**Data Element Name**	**Max Length**	**Data Type Guide**	**Description**	**Release Notes**	**Edit Level**	**APCD Threshold**	**Public / Restricted**	**Masked**
44	ME112	Pharmacy Deductible	19	money	Maximum out of pocket amount of member's deductible applied to pharmacy	Value representing the maximum amount of the Member's deductible that is applied to pharmacy before certain prescriptions are covered.	B	90%	P	No
45	ME113	Medical and Pharmacy Deductible	19	money	Maximum out of pocket amount of member's deductible applied to services	Value representing the maximum amount of the Member's deductible that is applied before certain medical services and prescriptions are covered, when the deductible is not strictly based on medical or strictly on pharmacy out of pocket costs, but on the combination of the two.	B	90%	P	No
46	ME114	Behavioral Health Deductible	19	money	Maximum out of pocket amount of member's deductible applied to behavioral health	Value representing the maximum amount of the Member's deductible that is applied to behavioral health services before certain behavioral health services are covered.	B	90%	P	No
47	ME115	Dental Deductible	19	money	Maximum out of pocket amount of member's deductible applied to dental services	Value representing the maximum amount of the Member's deductible that is applied to dental services before certain dental services are covered.	B	90%	P	No
48	ME116	Vision Deductible	19	money	Maximum out of pocket amount of member's deductible applied to vision services	Value representing the maximum amount of the Member's deductible that is applied to vision services before certain vision services are covered.	B	90%	P	No
49	ME118	Vision Benefit	1	varchar	Indicates if Vision Services are a covered benefit in the member's eligibility (Lookup Table)	Numeric indicator that reports if the Member has vision coverage as a benefit during the time-period of this eligibility segment.	A0	100%	P	No
50	ME899	Record Type	2	varchar	File Type Identifier	The APCD filing-type identifier that defines the data contained within the file.	A0	100%	P	No
51	ME001 / ME036	Health Care Home Number	256	varbinary	Submitter Org ID as defined by DHCFP/ Carrier-assigned Provider ID for Health Care Home	Combined Payer/Provider ID for de-identified linking. Masked value. Can be linked to hashed value in elements with the same combined ID values.			P	Yes

Member Eligibility File - Public Use Data Elements										
Order	**Element**	**Data Element Name**	**Max Length**	**Data Type Guide**	**Description**	**Release Notes**	**Edit Level**	**APCD Threshold**	**Public / Restricted**	**Masked**
52	ME001 / ME040	Product ID Number	256	varbinary	Submitter Org ID as defined by DHCFP/ Product Identification Number	Combined Payer/ Product ID for de-identified linking. Masked value. Can be linked to masked value in elements with the same combined ID values.			P	Yes
53	ME001 / ME107	Payer / CarrierSpecificUniqueMemberID	256	varbinary	Submitter Org ID as defined by DHCFP/ Carrier-assigned Member/Patient Unique ID	Combined Payer/ Member ID for de-identified linking. Masked value. Can be linked to masked value in elements with the same combined ID values.			P	Yes
54	ME001 / ME117	Payer / CarrierSpecificUniqueSubscriberID	256	varbinary	Submitter Org ID as defined by DHCFP/ Subscriber Carrier Unique Identification	Combined Payer/ Subscriber ID for de-identified linking. Masked value. Can be linked to masked value in elements with the same combined ID values.			P	Yes
55	Derived by DHCFP	Unique Record ID: Public File	10	Int	Unique Record ID - Derived by DHCFP	Unique Record ID for Member Eligibility record: Restricted File value matches Public File value for the same record.			P	No

Member Eligibility File - Restricted Use Data Elements										
Order	**Element**	**Data Element Name**	**Max Length**	**Data Type Guide**	**Description**	**Release Notes**	**Edit Level**	**APCD Threshold**	**Public / Restricted**	**Masked**
1	ME001	Payer	256	varbinary	Carrier Specific Submitter Code as defined by APCD. This must match the Submitter Code reported in HD002	A Division-assigned identifier for any APCD Data Submitter; Insurance, Benefit Manager/Administrator, TPA, Vendor, etc.	A0	100%	R	Yes
2	ME002	National Plan ID	256	varbinary	CMS National Plan Identification Number (PlanID)	Unique identifier as outlined by Centers for Medicare and Medicaid Services (CMS) for Plans.	Z	0%	R	Yes
3	ME006	Insured Group or Policy Number	256	varbinary	Carrier's group or policy number	The carrier assigned group / policy number for this eligibility segment.	A2	99%	R	Yes

Member Eligibility File - Restricted Use Data Elements										
Order	**Element**	**Data Element Name**	**Max Length**	**Data Type Guide**	**Description**	**Release Notes**	**Edit Level**	**APCD Threshold**	**Public / Restricted**	**Masked**
4	ME012	Individual Relationship Code	2	varchar	Member/Patient to Subscriber Relationship Code (Lookup Table	Numeric indicator to define the Member's relationship to the Subscriber.	A0	97%	R	No
5	ME014/ Month	Member Birth Month	10	int	Member Birth Month / Derived by DHCFP	Month of the Date of Birth of the Member.			R	No
6	ME015	Member City Name	128	varchar	City name of the Member	City of the Member.	A0	99%	R	No
7	ME017/First3	First 3 of Member zip code	3	varchar	First 3 of Member zip code / Derived by DHCFP	First 3 digits of the Zip Code of the Member			R	No
8	ME031	Special Coverage	3	varchar	Special Coverage Code (Lookup Table)	A code that reports special coverage type under Commonwealth Care or the Health Safety Net during the time-period of this eligibility segment. Value of N/A indicates any other type of coverage.	B	0%	R	No
9	ME036	Health Care Home Number	256	varbinary	Health Care Home Number	Link to PV002 on the Provider File to obtain detailed attributes of the Health Care Home. (Refer to Linking section of Release Document.)	C	90%	R	Yes
10	ME040	Product ID Number	256	varbinary	Product Identification Number	Link to PR001 on the Product File to obtain detailed attributes of the product that this eligibility segment is associated to. (Refer to Linking section of Release Document.)	A0	100%	R	Yes
11	ME041	Product Enrollment Start Date	23	datetime	The date the member was enrolled in the product	The date the Member enrolled in the product. (YYYY-MM-DD 00:00:00.000)	A1	98%	R	No
12	ME042	Product Enrollment End Date	23	datetime	End Date of the Member's Enrollment in the Product	The date the Member dis-enrolled in the product. If the Member is not dis-enrolled, date is null. (YYYY-MM-DD 00:00:00.000)	B	98%	R	No

Member Eligibility File - Restricted Use Data Elements										
Order	**Element**	**Data Element Name**	**Max Length**	**Data Type Guide**	**Description**	**Release Notes**	**Edit Level**	**APCD Threshold**	**Public / Restricted**	**Masked**
13	ME046	Member PCP ID	256	varbinary	Member's PCP Identification Number	Link to PV002 on the Provider File to obtain detailed attributes of the Member's Primary Care Provider. (Values of '999999999U' when PCP is unknown and '999999999NA' if the product does not require a PCP.)	B	98%	R	Yes
14	ME075	NewMMISID	256	varbinary	NewMMIS Identification Number	Unique ID used by NewMMIS to identify a Member. (This field is for MassHealth, Medicaid MCOs, or Carriers that offer Commonwealth Care.)	B	98%	R	Yes
15	ME076	Member rating category	2	varchar	Member Rating Category Code (Carrier Defined Reference Table)	The rating category of the Member as defined by the carrier or its designee.	B	90%	R	No
16	ME079	Recipient Identification Number (MassHealth only)	256	varbinary	MassHealth RID Number	The current Medicaid identification number assigned to the individual by MassHealth. This field is for MassHealth or Medicaid MCOs only.	B	98%	R	Yes
17	ME080	Recipient Historical Number (MassHealth only)	256	varbinary	MassHealth RHN Number	The permanent Medicaid identification number assigned to the individual by MassHealth. This field is for MassHealth or Medicaid MCOs only.	B	98%	R	Yes
18	ME107	CarrierSpecificUniqueMemberID	256	varbinary	Member/Patient Carrier Unique Identification	Unique, internal identification assigned by the carrier or its designee to the Member. This can be used to link eligibility segments to Claim Lines. (Refer to Linking section of Release Document.)	A0	100%	R	Yes
19	ME108	Subscriber City Name	128	varchar	City name of the Subscriber	City of the Subscriber.	A0	98%	R	No
20	ME110/First3	First 3 of Subscriber zip code	3	varchar	First 3 of Subscriber zip code / Derived by DHCFP	First 3 digits of the Zip Code of the Subscriber.			R	No

Member Eligibility File - Restricted Use Data Elements										
Order	**Element**	**Data Element Name**	**Max Length**	**Data Type Guide**	**Description**	**Release Notes**	**Edit Level**	**APCD Threshold**	**Public / Restricted**	**Masked**
21	ME117	CarrierSpecificUniqueSubscriberID	256	varbinary	Subscriber Carrier Unique Identification	Unique, internal identification assigned by the carrier or its designee to the Subscriber. This can be used to link eligibility segments to Claim Lines. (Refer to Linking section of Release Document.)	A0	100%	R	Yes
22	ME001 / ME046	Payer / Member PCP ID	256	varbinary	Submitter Org ID as defined by DHCFP/ Member's Carrier-Defined PCP ID	Combined Payer/ PCP ID for de-identified linking. Masked value. Can be linked to masked value in elements with the same combined ID values.			R	Yes
23	ME001 / ME076	Payer / Member rating category	256	varbinary	Submitter Org ID as defined by DHCFP/ Member Rating Category Code (as defined by Carrier)	Combined Payer ID/ Member Rating Category Code for de-identified linking. Use this masked field value to link to the code Description in the **Carrier-Specific Master Lookup Table.**			R	Yes
24	Derived by DHCFP	Unique Record ID: Restricted File	10	int	Unique Record ID - Derived by DHCFP	Unique Record ID for Member Eligibility record: Restricted File value matches Public File value for the same record.			R	No

Member Eligibility File - Unavailable Data Elements							
Order		**Data Element Name**	**Description**	**Release Notes**	**Edit Level**	**APCD Threshold**	**Public / Restricted**
1	ME004	Year	Eligibility year reported in this submission.	Year for which eligibility is reported in this submission period. Previous year's data in this file will not match current year.	A0	100%	not released
2	ME005	Month	Reporting Month of Eligibility	Month for which eligibility is reported in the submission.	A0	100%	not released
3	ME008	Subscriber Unique Identification Number	Subscriber's Social Security Number	Tax ID of the Subscriber.	A0	85%	not released

Member Eligibility File - Unavailable Data Elements							
Order		**Data Element Name**	**Description**	**Release Notes**	**Edit Level**	**APCD Threshold**	**Public / Restricted**
4	ME009	Plan Specific Contract Number	Contract Number	Plan-assigned contract/certificate number for the Subscriber and all of the corresponding dependents. This identifier must not disclose individuals.	B	89%	not released
5	ME010	Member Suffix or Sequence Number	Member's Contract Sequence Number	The unique identifier assigned to each beneficiary (member) under a contract.	B	99%	not released
6	ME011	Member Identification Code	Member's Social Security Number	Tax ID of the Member.	A2	68%	not released
7	ME014	Member Date of Birth	Member's date of birth	Birth date of the Member.	A0	99%	not released
8	ME017	Member ZIP Code	Zip Code of the Member (External Code Source 3)	5 or 9 digit Zip Code of the Member.	A0	99%	not released
9	ME032	Group Name	Group name	Name of the Group that this eligibility segment is associated with. Value of IND indicates a non-group as an Individual Policy.	B	80%	not released
10	ME043	Member Street Address	Street address of the Member	Street address of the Member.	A0	90%	not released
11	ME044	Member Address 2	Secondary Street Address of the Member	Street address 2 of the Member.	B	2%	not released
12	ME054	Eligibility Determination Date - GIC Only	Eligibility date	The date that the Member's eligibility was determined, by the carrier or its designee, for the time-period of this eligibility segment.	B	0%	not released
13	ME056	Last Activity Date - GIC Only	Activity Date	The date of last activity to the Members enrollment record.	B	0%	not released
14	ME057	Date of Death - GIC Only	Member's Date of Death	Date of Death of the Member, when known.	C	0%	not released
15	ME057/Year	Year of Death - Derived by DHCFP	Year of Death - Derived by DHCFP	Year of the Date of Death of the Member, when known, derived by DHCFP.			not released

Member Eligibility File - Unavailable Data Elements							
Order		**Data Element Name**	**Description**	**Release Notes**	**Edit Level**	**APCD Threshold**	**Public / Restricted**
16	ME058	Subscriber Street Address	Street address of the Subscriber	Street address of the Subscriber.	A0	98%	not released
17	ME060	Employment Status - GIC Only	Employment Status Code (Lookup Table)	A code that reports the employment status of the Member as defined by the carrier or its designee of GIC enrollees during the time-period of this eligibility segment.	B	0%	not released
18	ME065	Date of Retirement - GIC Only	Member's date of Retirement	Date GIC employee retired.	B	0%	not released
19	ME067	Spouse Plan Type - GIC Only	Spouse Plan Type Code (Carrier Defined Reference Table)	Used when spouse of employee selects Medicare coverage, separate from GIC.	C	0%	not released
20	ME068	Spouse Plan - GIC Only	Spouse Plan Medicare Code (Carrier Defined Reference Table)	Used when spouse of employee selects Medicare coverage, separate from GIC.	C	0%	not released
21	ME069	Spouse Medical Coverage - GIC Only	Spouse Medical Medicare Coverage Code (Carrier Defined Reference Table)	Used when spouse of employee selects Medicare coverage, separate from GIC.	C	0%	not released
22	ME070	Spouse Medicare Indicator - GIC Only	Spouse Medicare Selected Code (Carrier Defined Reference Table)	Used when spouse of employee selects Medicare coverage, separate from GIC.	C	0%	not released
23	ME071	Pool Indicator - GIC Only	Pool Indicator Code (Lookup Table)	Numeric indicator that reports the risk pool that a GIC Member has been assigned by the carrier or its designee during the time-period of this eligibility segment.	B	0%	not released
24	ME082	Employer Name	Member's Employer Name	Name of the Subscriber's employer during the time-period of this eligibility segment.	B	90%	not released
25	ME083	Employer EIN	Member's Employer EIN	Tax ID of the Employer.	B	90%	not released
26	ME101	Subscriber Last Name	Last name of Subscriber	Last name, or entity name, of the Subscriber.	A0	100%	not released

Member Eligibility File - Unavailable Data Elements							
Ord-er		**Data Element Name**	**Description**	**Release Notes**	**Edit Level**	**APCD Thres-hold**	**Public / Restrict-ed**
27	ME102	Subscriber First Name	First name of the Subscriber	First name of Subscriber, when appropriate.	A0	100%	not released
28	ME103	Subscriber Middle Initial	Middle initial of Subscriber	Middle initial of the Subscriber.	C	2%	not released
29	ME104	Member Last Name	Last name of Member	Last name of the Member.	A0	100%	not released
30	ME105	Member First Name	First name of Member	First name of the Member.	A0	100%	not released
31	ME106	Member Middle Initial	Middle initial of Member	Middle initial of the Member.	C	2%	not released
32	ME110	Subscriber ZIP Code	Zip Code of the Subscriber (External Code Source 3)	5 or 9 digit Zip Code of the Subscriber.	A0	99%	not released
33	Derived by DHCFP	County of Member	County of Member / Derived by DHCFP	Not available.			not released
34	Derived by DHCFP	Geocoded Member Address	Geocoded Member Address / Derived by DHCFP	Not available.			not released

Member Eligibility File Lookup Tables, by Element										
Order	**Element**	**Data Element Name**	**Max Length**	**Data Type Guide**	**Description**	**Release Notes**	**Edit Level**	**APCD Threshold**	**Public / Restricted**	**Masked**
1	ME003	Insurance Type Code/Product	2	varchar	Type / Product Identification Code (Lookup Table)	A code that defines the type of insurance applied to this eligibility segment by the carrier or its designee.	A1	96%	P	No
					Insurance Type Code	***Insurance Type***				
					12	Preferred Provider Organization (PPO)				
					13	Point of Service (POS)				
					14	Exclusive Provider Organization (EPO)				
					15	Indemnity Insurance				
					16	Health Maintenance Organization (HMO) Medicare Advantage				
					17	Dental Maintenance Organization (DMO)				
					AM	Automobile Medical				
					DS	Disability				
					HM	Health Maintenance Organization				
					HN	HMO Medicare Risk/Medicare Part C				
					LI	Liability				
					LM	Liability Medical				
					MA	Medicare Part A				
					MB	Medicare Part B				
					MC	Medicaid				
					MD	Medicare Part D				
					MO	Medicaid Managed Care Organization				
					MP	Medicare Primary				
					OF	Other Federal Program (e.g. Black Lung)				

Member Eligibility File Lookup Tables, by Element										
Order	**Element**	**Data Element Name**	**Max Length**	**Data Type Guide**	**Description**	**Release Notes**	**Edit Level**	**APCD Threshold**	**Public / Restricted**	**Masked**
					QM	Qualified Medicare Beneficiary				
					SC	Senior Care Option				
					SP	Supplemental Policy				
					TV	Title V				
					VA	Veterans Administration Plan				
					WC	Workers' Compensation				
2	ME007	Coverage Level Code	3	varchar	Benefit Coverage Level Code (Lookup Table)	A code that reports relationships which are covered under the benefits during the time-period of this eligibility segment.	A1	99%	P	No
					Coverage Level Code	***Coverage Level***				
					CHD	Children Only				
					DEP	Dependents Only				
					ECH	Employee and Children				
					ELF	Employee and Life Partner				
					EMP	Employee Only				
					ESP	Employee and Spouse				
					FAM	Family				
					IND	Individual				
					SPC	Spouse and Children				
					SPO	Spouse Only				
4	ME012	Individual Relationship Code	2	Integer	Member/Patient to Subscriber Relationship Code (Lookup Table)	Numeric indicator to define the Member's relationship to the Subscriber.	A0	97%	R	No
					Individual Relationship Code	***Individual Relationship***				
					1	Spouse				

Member Eligibility File Lookup Tables, by Element										
Ord-er	**Element**	**Data Element Name**	**Max Length**	**Data Type Guide**	**Description**	**Release Notes**	**Edit Level**	**APCD Thres-hold**	**Public / Restrict-ed**	**Mask -ed**
					4	Grandfather or Grandmother				
					5	Grandson or Granddaughter				
					7	Nephew or Niece				
					10	Foster Child				
					15	Ward				
					17	Stepson or Stepdaughter				
					19	Child				
					20	Self/Employee				
					21	Unknown				
					22	Handicapped Dependent				
					23	Sponsored Dependent				
					24	Dependent of a Minor Dependent				
					29	Significant Other				
					32	Mother				
					33	Father				
					36	Emancipated Minor				
					39	Organ Donor				
					40	Cadaver Donor				
					41	Injured Plaintiff				
					43	Child Where Insured Has No Financial Responsibility				
					53	Life Partner				
					76	Dependent				

Member Eligibility File Lookup Tables, by Element										
Order	**Element**	**Data Element Name**	**Max Length**	**Data Type Guide**	**Description**	**Release Notes**	**Edit Level**	**APCD Threshold**	**Public / Restricted**	**Masked**
3	ME013	Member Gender	1	varchar	The Member's Gender (Lookup Table)	A code that defines the Member's gender.	A0	100%	P	No
					Gender Code	***Gender***				
					F	Female				
					M	Male				
					O	Other				
					U	Unknown				
6	ME018	Medical Coverage	1	varchar	Indicator to refine Product or define Benefit within a Product. (Lookup Table)	Numeric indicator that reports if the Member has medical coverage as a benefit during the time-period of this eligibility segment.	A0	100%	P	No
					Value	***Description***				
					1	Yes				
					2	No				
					3	Unknown				
					4	Other				
					5	Not Applicable				
7	ME019	Prescription Drug Coverage	1	varchar	Indicator to refine Product or define Benefit within a Product. (Lookup Table)	Numeric indicator that reports if the Member has prescription drug coverage as a benefit during the time-period of this eligibility segment.	A0	100%	P	No
					Value	***Description***				
					1	Yes				
					2	No				
					3	Unknown				
					4	Other				
					5	Not Applicable				

Member Eligibility File Lookup Tables, by Element										
Order	**Element**	**Data Element Name**	**Max Length**	**Data Type Guide**	**Description**	**Release Notes**	**Edit Level**	**APCD Threshold**	**Public / Restricted**	**Masked**
8	ME020	Dental Coverage	1	varchar	Indicator to refine Product or define Benefit within a Product. (Lookup Table)	Numeric indicator that reports if the Member has dental coverage as a benefit during the time-period of this eligibility segment.	A0	100%	P	No
					Value	***Description***				
					1	Yes				
					2	No				
					3	Unknown				
					4	Other				
					5	Not Applicable				
9	ME021	Race 1	6	varchar	Member's self-disclosed Primary Race (Lookup Table)	A code that reports the self-disclosed primary race of the Member. A value of R9 (Other Race) requires narrative of this race in Other Race.	B	3%	P	No
					Race Code	***Race***				
					R1	American Indian/Alaska Native				
					R2	Asian				
					R3	Black/African American				
					R4	Native Hawaiian or other Pacific Islander				
					R5	White				
					R9	Other Race				
					UNKNOW	Unknown/not specified				

Member Eligibility File Lookup Tables, by Element										
Order	**Element**	**Data Element Name**	**Max Length**	**Data Type Guide**	**Description**	**Release Notes**	**Edit Level**	**APCD Threshold**	**Public / Restricted**	**Masked**
10	ME022	Race 2	6	varchar	Member's self-disclosed Secondary Race (Lookup Table)	A code that reports the self-disclosed secondary race of the Member. A value of R9 (Other Race) requires narrative of this race in Other Race.	C	2%	P	No
					Race Code	***Race***				
					R1	American Indian/Alaska Native				
					R2	Asian				
					R3	Black/African American				
					R4	Native Hawaiian or other Pacific Islander				
					R5	White				
					R9	Other Race				
					UNKNOW	Unknown/not specified				
12	ME024	Hispanic Indicator	1	varchar	Indicator to define Hispanic status (Lookup Table)	Numeric indicator that reports if the Member has self-disclosed Hispanic heritage during the time-period of this eligibility segment.	B	3%	P	No
					Value	***Description***				
					1	Yes				
					2	No				
					3	Unknown				
					4	Other				
					5	Not Applicable				

Member Eligibility File Lookup Tables, by Element										
Order	**Element**	**Data Element Name**	**Max Length**	**Data Type Guide**	**Description**	**Release Notes**	**Edit Level**	**APCD Threshold**	**Public / Restricted**	**Masked**
13	ME025	Ethnicity 1	6	varchar	Member's self-disclosed Primary Ethnicity (Lookup Table)	A code that reports the self-disclosed primary ethnicity of the Member. A value of OTHER requires narrative of this ethnicity in Other Ethnicity.	B	3%	P	No
					Ethnicity Code	***Ethnicity***				
					2182-4	Cuban				
					2184-0	Dominican				
					2148-5	Mexican, Mexican American, Chicano				
					2180-8	Puerto Rican				
					2161-8	Salvadoran				
					2155-0	Central American (not otherwise specified)				
					2165-9	South American (not otherwise specified)				
					2060-2	African				
					2058-6	African American				
					AMERCN	American				
					2028-9	Asian				
					2029-7	Asian Indian				
					BRAZIL	Brazilian				
					2033-9	Cambodian				
					CVERDN	Cape Verdean				
					CARIBI	Caribbean Island				
					2034-7	Chinese				
					2169-1	Columbian				
					2108-9	European				

Member Eligibility File Lookup Tables, by Element										
Ord-er	**Element**	**Data Element Name**	**Max Length**	**Data Type Guide**	**Description**	**Release Notes**	**Edit Level**	**APCD Thres-hold**	**Public / Restrict-ed**	**Mask -ed**
					2036-2	Filipino				
					2157-6	Guatemalan				
					2071-9	Haitian				
					2158-4	Honduran				
					2039-6	Japanese				
					2040-4	Korean				
					2041-2	Laotian				
					2118-8	Middle Eastern				
					PORTUG	Portuguese				
					RUSSIA	Russian				
					EASTEU	Eastern European				
					2047-9	Vietnamese				
					OTHER	Other Ethnicity				
					UNKNOW	Unknown/not specified				
14	ME026	Ethnicity 2	6	varchar	Member's self-disclosed Secondary Ethnicity (Lookup Table)	A code that reports the self-disclosed primary ethnicity of the Member. A value of OTHER requires narrative of this ethnicity in Other Ethnicity.	C	2%	P	No
					Ethnicity Code	***Ethnicity***				
					2182-4	Cuban				
					2184-0	Dominican				
					2148-5	Mexican, Mexican American, Chicano				
					2180-8	Puerto Rican				
					2161-8	Salvadoran				
					2155-0	Central American (not otherwise specified)				

Member Eligibility File Lookup Tables, by Element										
Ord-er	**Element**	**Data Element Name**	**Max Length**	**Data Type Guide**	**Description**	**Release Notes**	**Edit Level**	**APCD Thres-hold**	**Public / Restrict-ed**	**Mask -ed**
					2165-9	South American (not otherwise specified)				
					2060-2	African				
					2058-6	African American				
					AMERCN	American				
					2028-9	Asian				
					2029-7	Asian Indian				
					BRAZIL	Brazilian				
					2033-9	Cambodian				
					CVERDN	Cape Verdean				
					CARIBI	Caribbean Island				
					2034-7	Chinese				
					2169-1	Columbian				
					2108-9	European				
					2036-2	Filipino				
					2157-6	Guatemalan				
					2071-9	Haitian				
					2158-4	Honduran				
					2039-6	Japanese				
					2040-4	Korean				
					2041-2	Laotian				
					2118-8	Middle Eastern				
					PORTUG	Portuguese				
					RUSSIA	Russian				
					EASTEU	Eastern European				

Member Eligibility File Lookup Tables, by Element										
Order	**Element**	**Data Element Name**	**Max Length**	**Data Type Guide**	**Description**	**Release Notes**	**Edit Level**	**APCD Threshold**	**Public / Restricted**	**Masked**
					2047-9	Vietnamese				
					OTHER	Other Ethnicity				
					UNKNOW	Unknown/not specified				
16	ME028	Primary Insurance Indicator	1	varchar	Indicator to define if Insurance is Primary (Lookup Table)	Numeric indicator that reports if the Member's eligibility is for primary insurance during the time-period of this eligibility segment.	A0	80%	P	No
					Value	***Description***				
					1	Yes				
					2	No				
					3	Unknown				
					4	Other				
					5	Not Applicable				
17	ME029	Coverage Type	3	varchar	Type of Coverage Code (Lookup Table)	A code that reports the risk-type of the carrier the Member is covered under during the time-period stated on this eligibility segment.	A0	90%	P	No
					Coverage Type Code	***Coverage Type***				
					ASW	self-funded plans that are administered by a third-party administrator, where the employer has purchased stop-loss, or group excess, insurance coverage				
					ASO	self-funded plans that are administered by a third-party administrator, where the employer has not purchased stop-loss, or group excess, insurance coverage				
					STN	short-term, non-renewable health insurance				
					UND	plans underwritten by the insurer				

Member Eligibility File Lookup Tables, by Element										
Ord-er	**Element**	**Data Element Name**	**Max Length**	**Data Type Guide**	**Description**	**Release Notes**	**Edit Level**	**APCD Thres-hold**	**Public / Restrict-ed**	**Mask -ed**
					OTH	Any other plan. Insurers using this code shall obtain prior approval.				
18	ME030	Market Category Code	4	varchar	Market Category Code (Lookup Table)	A code that reports the market the policy is sold into by the carrier or its designee during the time-period of this eligibility segment. Use this code to map to individuals and group sizes.	A0	95%	P	No
					Market Category Code	***Market Category***				
					IND	Policies sold and issued directly to individuals (non-group)				
					FCH	Policies sold and issued directly to individuals on a franchise basis				
					GCV	Policies sold and issued directly to individuals as group conversion Policies				
					GS1	Policies sold and issued directly to employers having exactly one employee				
					GS2	Policies sold and issued directly to employers having between two and nine employees				
					GS3	Policies sold and issued directly to employers having between 10 and 25 employees				
					GS4	Policies sold and issued directly to employers having between 26 and 50 employees				
					GLG1	Policies sold and issued directly to employers having between 51 and 99 employees				
					GLG2	Policies sold and issued directly to employers having between 100 and 249 employees				

Member Eligibility File Lookup Tables, by Element										
Ord-er	**Element**	**Data Element Name**	**Max Length**	**Data Type Guide**	**Description**	**Release Notes**	**Edit Level**	**APCD Thres-hold**	**Public / Restrict-ed**	**Mask -ed**
					GLG3	Policies sold and issued directly to employers having between 250 and 499 employees				
					GLG4	Policies sold and issued directly to employers having 500 or more employees				
					GSA	Policies sold and issued directly to small employers through a qualified association trust				
					OTH	Policies sold to other types of entities. Insurers using this market code shall obtain prior approval.				
8	ME031	Special Coverage	3	varchar	Special Coverage Code (Lookup Table)	A code that reports special coverage type under Commonwealth Care or the Health Safety Net during the time-period of this eligibility segment. Value of N/A indicates any other type of coverage.	B	0%	R	No
					Special Coverage Code	***Special Coverage***				
					CC	Commonwealth Care				
					HSN	Health Safety Net				
					N/A	Not Applicable				
19	ME033	Member language preference	3	varchar	Member's self-disclosed verbal language preference (Lookup Table)	A code that reports the self-disclosed verbal language preference of the Member. A value of 708, 799 or 997 requires narrative of this language preference in Other Member Language Preference.	B	3%	P	No
					Language Preference Code	***Language Preference***				
					600	English				
					601	Cape Verdean Creole				

Member Eligibility File Lookup Tables, by Element										
Ord-er	**Element**	**Data Element Name**	**Max Length**	**Data Type Guide**	**Description**	**Release Notes**	**Edit Level**	**APCD Thres-hold**	**Public / Restrict-ed**	**Mask -ed**
					607	German				
					619	Italian				
					620	French				
					623	Haitian Creole				
					625	Spanish				
					629	Portuguese				
					637	Greek				
					639	Russian				
					645	Polish				
					656	Persian				
					663	Hindi				
					671	Urdu				
					708	Chinese (Please specify in ME034)				
					723	Japanese				
					724	Korean				
					728	Vietnamese				
					742	Tagalog				
					777	Arabic				
					778	Hebrew				
					799	African (Please specify in ME034)				
					997	Other Language (Please specify in ME034)				
					999	Unknown / not specified				

Member Eligibility File Lookup Tables, by Element										
Order	**Element**	**Data Element Name**	**Max Length**	**Data Type Guide**	**Description**	**Release Notes**	**Edit Level**	**APCD Threshold**	**Public / Restricted**	**Masked**
21	ME035	Health Care Home Assigned Flag	1	varchar	Health Care Home Assigned indicator (Lookup Table)	Numeric indicator that reports if the Member has been assigned to a Health Care Home by the carrier or its designee during the time-period of this eligibility segment.	B	20%	P	No
					Value	***Description***				
					1	Yes				
					2	No				
					3	Unknown				
					4	Other				
					5	Not Applicable				
29	ME051	Behavioral Health Benefit Flag	1	varchar	Indicates if Behavioral / Mental Health is a covered benefit in the member's eligibility (Lookup Table)	Numeric indicator that reports if the Member has behavioral health coverage as a benefit during the time-period of this eligibility segment.	B	100%	P	No
					Value	***Description***				
					1	Yes				
					2	No				
					3	Unknown				
					4	Other				
					5	Not Applicable				
30	ME052	Laboratory Benefit Flag	1	varchar	Laboratory Benefits indicator (Lookup Table)	Numeric indicator that reports if the Member has laboratory coverage as a benefit during the time-period of this eligibility segment.	B	100%	P	No
					Value	***Description***				
					1	Yes				
					2	No				

Member Eligibility File Lookup Tables, by Element										
Order	**Element**	**Data Element Name**	**Max Length**	**Data Type Guide**	**Description**	**Release Notes**	**Edit Level**	**APCD Threshold**	**Public / Restricted**	**Masked**
					3	Unknown				
					4	Other				
					5	Not Applicable				
31	ME053	Disease Management Enrollee Flag	1	varchar	Chronic Illness Management indicator (Lookup Table)	Numeric indicator that reports if the carrier, or its designee, is managing the Member's chronic illness during the time-period of this eligibility segment.	B	100%	P	No
					Value	***Description***				
					1	Yes				
					2	No				
					3	Unknown				
					4	Other				
					5	Not Applicable				
32	ME059	Disability Indicator Flag	1	varchar	Disability Identifier (Lookup Table)	Numeric indicator that reports if the Member is on Disability during the time-period of this eligibility segment.	C	100%	P	No
					Value	***Description***				
					1	Yes				
					2	No				
					3	Unknown				
					4	Other				
					5	Not Applicable				
19	ME060	Employment Status - GIC Only	1	varchar	Employment Status Code (Lookup Table)	A code that reports the employment status of the Member as defined by the carrier or its designee of GIC enrollees during the time-period of this eligibility segment.	B	0%	not released	
					Employment Status Code	***Employment Status***				

Member Eligibility File Lookup Tables, by Element										
Ord-er	**Element**	**Data Element Name**	**Max Length**	**Data Type Guide**	**Description**	**Release Notes**	**Edit Level**	**APCD Thres-hold**	**Public / Restrict-ed**	**Mask -ed**
					A	Active				
					I	Involuntary Leave				
					O	Orphan				
					P	Pending				
					R	Retiree				
					U	Unknown				
					Z	Unemployed				
33	ME061	Student Status	1	varchar	Student Status Indicator (Lookup Table)	Numeric indicator that reports if the Member is a student during the time-period stated on this eligibility segment.	A0	100%	P	No
					Value	***Description***				
					1	Yes				
					2	No				
					3	Unknown				
					4	Other				
					5	Not Applicable				
34	ME062	Marital Status	1	varchar	Marital Status Code (Lookup Table)	A code that reports the marital status of the Member during the time-period of this eligibility segment.	B	100%	P	No
					Marital Status Code	***Marital Status***				
					S	Never Married				
					M	Married				
					X	Legally Separated				
					D	Divorced				
					U	Unknown				
					W	Widowed				

Member Eligibility File Lookup Tables, by Element										
Order	**Element**	**Data Element Name**	**Max Length**	**Data Type Guide**	**Description**	**Release Notes**	**Edit Level**	**APCD Threshold**	**Public / Restricted**	**Masked**
35	ME063	Benefit Status	1	varchar	Benefit Status Code (Lookup Table)	A code that reports the benefit status of the Member during the time-period of this eligibility segment.	B	100%	P	No
					Benefit Status Code	***Benefit Status***				
					A	Active				
					C	COBRA				
					S	Surviving Insured				
					T	TEFRA				
					U	Unknown				
36	ME064	Employee Type	1	varchar	Employee Type Code (Lookup Table)	A code that reports the employee's employment type during the time-period of this eligibility segment.	C	100%	P	No
					Employee Type Code	***Employee Type***				
					H	Hourly				
					S	Salaried				
					T	Temporary				
					U	Unknown				
37	ME066	COBRA Status	1	varchar	COBRA usage indicator (Lookup Table)	Numeric indicator that reports if the Member is covered under COBRA during the time-period of this eligibility segment.	B	80%	P	No
					Value	***Description***				
					1	Yes				
					2	No				
					3	Unknown				
					4	Other				
					5	Not Applicable				

Member Eligibility File Lookup Tables, by Element										
Order	**Element**	**Data Element Name**	**Max Length**	**Data Type Guide**	**Description**	**Release Notes**	**Edit Level**	**APCD Threshold**	**Public / Restricted**	**Masked**
25	ME071	Pool Indicator - GIC Only	2	varchar	Pool Indicator Code (Lookup Table)	Numeric indicator that reports the risk pool that a GIC Member has been assigned by the carrier or its designee during the time-period of this eligibility segment.	B	0%	not released	
					Pool Indicator Code	***Pool Indicator***				-
					1	Regular State Employees and Retirees, plus local authorities				-
					2	Elderly Governmental Retirees (EGR) and Retired Municipal Teachers (RMTs)				-
38	ME073	Fully insured member	1	varchar	Fully Insured identifier (Lookup Table)	Numeric indicator that reports if the Member is Fully Insured during the time-period of this eligibility segment.	A0	100%	P	No
					Value	***Description***				
					1	Yes				
					2	No				
					3	Unknown				
					4	Other				
					5	Not Applicable				
39	ME074	Interpreter	1	varchar	Interpreter Required indicator (Lookup Table)	Numeric indicator that reports if the Member has self-disclosed a need for an interpreter during the time-period stated on this eligibility segment.	C	0%	P	No
					Value	***Description***				
					1	Yes				
					2	No				
					3	Unknown				
					4	Other				

Member Eligibility File Lookup Tables, by Element										
Order	**Element**	**Data Element Name**	**Max Length**	**Data Type Guide**	**Description**	**Release Notes**	**Edit Level**	**APCD Threshold**	**Public / Restricted**	**Masked**
					5	Not Applicable				
41	ME081	Medicare Code	1	varchar	Medicare Plan Indicator Code (Lookup Table)	Numeric indicator that reports the Medicare coverage level, if any, of the Member during the time-period of this eligibility segment.	B	100%	P	No
					Medicare Code	***Medicare Code Description***				
					0	No Medicare Coverage				
					1	Part A Only				
					2	Part B Only				
					3	Part A and B				
					4	Part C Only				
					5	Advantage				
					6	Part D Only				
49	ME118	Vision Benefit	1	varchar	Indicates if Vision Services are a covered benefit in the member's eligibility (Lookup Table)	Numeric indicator that reports if the Member has vision coverage as a benefit during the time-period of this eligibility segment.	A0	100%	P	No
					Value	***Description***				
					1	Yes				
					2	No				
					3	Unknown				
					4	Other				
					5	Not Applicable				

Member Eligibility File: External Code Sources

Refer to Appendix 2 in this document: External Code Sources

The APCD Medical Claims File

Medical Claims File - Public Use Data Elements										
Order	**Element**	**Data Element Name**	**Max Length**	**Data Type Guide**	**Description**	**Release Notes**	**Edit Level**	**APCD Threshold**	**Public / Restricted**	**Masked**
1	MC005	Line Counter	10	int	Incremental Line Counter	The line number for this service on the claim. First line should start with 1 and each additional line incremented by 1.	A0	100%	P	No
2	MC005A	Version Number	10	int	Claim service line version number	Incrementing counter for a claim line that is reprocessed for any reason over the course of time. Highest value should indicate latest reprocessing of line by the carrier/submitter.	A0	100%	P	No
3	MC012	Member Gender	1	varchar	Member/Patient's Gender (Lookup Table)	A code that defines the Patient's gender. This can be derived from the claim as submitted by the provider or reassigned by the carrier or its designee.	B	98%	P	No
4	MC013/ Year	Member Birth Year	10	int	Member/Patient's date of birth - Year Only	Derived by DHCFP from MC013. The Member Birth Year is reported as 999 when the Member is age 90 or older as of the Date of Service From date.			P	No
5	MC015	Member State or Province	2	varchar	State of the Member/Patient (External Code Source 2)	State of the Patient.	B	98%	P	No
6	MC020	Admission Type	1	varchar	Admission Type Code (External Code Source 10)	A standardized, numeric code that reports the type of admission into an inpatient setting. Also known as Admission Priority.	A1	98%	P	No
7	MC021	Admission Source	1	varchar	Admission Source Code (External Code Source 10)	A standardized code that reports the admission source of the Patient into an inpatient setting/facility and indicates how the Patient was referred into the inpatient setting.	A1	80%	P	No
8	MC023	Discharge Status	2	varchar	Inpatient Discharge Status Code (External Code Source 10)	A standardized, numeric code that reports the discharge status of the Patient.	A1	98%	P	No

Medical Claims File - Public Use Data Elements										
Order	**Element**	**Data Element Name**	**Max Length**	**Data Type Guide**	**Description**	**Release Notes**	**Edit Level**	**APCD Threshold**	**Public / Restricted**	**Masked**
9	MC026	National Service Provider ID	256	varbinary	National Provider Identification (NPI) of the Service Provider. (External Code Source 4)	The National Provider ID (NPI) of the Service Provider.	C	95%	P	Yes
10	MC027	Service Provider Entity Type Qualifier	1	varchar	Service Provider Entity Type Identifier Code (Lookup Table)	Numeric indicator to define the Service Provider as a **Person or Non-person.** This value drives various 'person' -type requirements; First Name, Date of Birth, Gender, etc.	A0	98%	P	No
11	MC028	Service Provider First Name	25	varchar	First name of Service Provider	First name of the Service Provider, when appropriate.	C	92%	P	No
12	MC029	Service Provider Middle Name	25	varchar	Middle initial of Service Provider	Middle name / initial of the Service Provider when appropriate.	C	2%	P	No
13	MC030	Servicing Provider Last Name or Organization Name	60	varchar	Last name or Organization Name of Service Provider	Last name, or Organization name, of the Servicing Provider.	A2	94%	P	No
14	MC031	Service Provider Suffix	10	varchar	Provider Name Suffix (Lookup Table)	The generational title of the provider when the Service Provider Entity Type = 1 (Person)	Z	2%	P	No
15	MC032	Service Provider Specialty	50	varchar	Specialty Code	A standardized taxonomy code (External Code Source 13) **OR** a carrier-defined specialty code of the Servicing Provider (APCD Master Lookup Table). Value is required to be in carrier-defined table if provided.	B	98%	P	No
16	MC033	Service Provider City Name	30	varchar	City Name of the Provider	City of the Service Provider.	B	98%	P	No

Medical Claims File - Public Use Data Elements										
Order	**Element**	**Data Element Name**	**Max Length**	**Data Type Guide**	**Description**	**Release Notes**	**Edit Level**	**APCD Threshold**	**Public / Restricted**	**Masked**
17	MC034	Service Provider State	2	varchar	State of the Service Provider (External Code Source 2)	State of the Service Provider.	B	98%	P	No
18	MC035	Service Provider ZIP Code	5	varchar	Zip Code of the Service Provider (External Code Source 3)	Zip Code of the Service Provider.	B	98%	P	No
19	MC036	Type of Bill - on Facility Claims	2	varchar	Type of Bill as used on Institutional Claims (External Code Source 10)	For Institutional Claims: a standardized code that reports the type of facility where the claim line service occurred.	A0	90%	P	No
20	MC037	Site of Service - on NSF/CMS 1500 Claims	2	varchar	Place of Service Code as used on Professional Claims (External Code Source 9)	For Professional Claims, a standardized code that reports the type of facility where the claim line service occurred.	A0	65%	P	No
21	MC038	Claim Status	2	varchar	Claim Line Status (Lookup Table)	Numeric indicator that reports if the claim line was paid by the carrier or its designee, and the COB order of the payment.	A0	98%	P	No
22	MC039	Admitting Diagnosis	7	varchar	Admitting Diagnosis Code (External Code Source 5)	Diagnostic code assigned by the provider to support admission into an inpatient setting at the facility reported in Plan Rendering Provider ID and Provider Location.	A1	98%	P	No
23	MC040	E-Code	7	varchar	ICD Diagnostic External Injury Code (External Code Source 5)	The ICD9 External Injury code for Patients with trauma or accidents.	C	3%	P	No
24	MC041	Principal Diagnosis	7	varchar	ICD Primary Diagnosis Code (External Code Source 5)	Primary ICD9 Diagnosis Code.	A0	99%	P	No
25	MC042	Other Diagnosis - 1	7	varchar	ICD Secondary Diagnosis Code (External Code Source 5)	Secondary ICD9 Diagnosis Code.	B	70%	P	No
26	MC043	Other Diagnosis - 2	7	varchar	ICD Other Diagnosis Code (External Code Source 5)	Other ICD9 Diagnosis Code 2.	B	24%	P	No
27	MC044	Other Diagnosis - 3	7	varchar	ICD Other Diagnosis Code (External Code Source 5)	Other ICD9 Diagnosis Code 3.	C	13%	P	No
28	MC045	Other Diagnosis - 4	7	varchar	ICD Other Diagnosis Code (External Code Source 5)	Other ICD9 Diagnosis Code 4.	C	7%	P	No

Medical Claims File - Public Use Data Elements										
Order	**Element**	**Data Element Name**	**Max Length**	**Data Type Guide**	**Description**	**Release Notes**	**Edit Level**	**APCD Threshold**	**Public / Restricted**	**Masked**
29	MC046	Other Diagnosis - 5	7	varchar	ICD Other Diagnosis Code (External Code Source 5)	Other ICD9 Diagnosis Code 5.	C	4%	P	No
30	MC047	Other Diagnosis - 6	7	varchar	ICD Other Diagnosis Code (External Code Source 5)	Other ICD9 Diagnosis Code 6.	C	3%	P	No
31	MC048	Other Diagnosis - 7	7	varchar	ICD Other Diagnosis Code (External Code Source 5)	Other ICD9 Diagnosis Code 7.	C	3%	P	No
32	MC049	Other Diagnosis - 8	7	varchar	ICD Other Diagnosis Code (External Code Source 5)	Other ICD9 Diagnosis Code 8.	C	2%	P	No
33	MC050	Other Diagnosis - 9	7	varchar	ICD Other Diagnosis Code (External Code Source 5)	Other ICD9 Diagnosis Code 9.	C	1%	P	No
34	MC051	Other Diagnosis - 10	7	varchar	ICD Other Diagnosis Code (External Code Source 5)	Other ICD9 Diagnosis Code 10.	C	1%	P	No
35	MC052	Other Diagnosis - 11	7	varchar	ICD Other Diagnosis Code (External Code Source 5)	Other ICD9 Diagnosis Code 11.	C	1%	P	No
36	MC053	Other Diagnosis - 12	7	varchar	ICD Other Diagnosis Code (External Code Source 5)	Other ICD9 Diagnosis Code 12.	C	1%	P	No
37	MC054	Revenue Code	10	varchar	Revenue Code as defined for use on an Institutional Claim (External Code Source 10)	A standardized code that reports the revenue center of a facility where the claim line service occurred.	A0	90%	P	No
38	MC055	Procedure Code	10	varchar	HCPCS / CPT Code (External Code Source 7)	The procedure code reported for this claim line.	A1	92%	P	No
39	MC056	Procedure Modifier - 1	2	varchar	HCPCS / CPT Code Modifier (External Code Source 7)	The first modifier for the procedure code reported on this claim line.	B	20%	P	No
40	MC057	Procedure Modifier - 2	2	varchar	HCPCS / CPT Code Modifier (External Code Source 7)	The second modifier for the procedure code reported on this claim line.	B	3%	P	No

Medical Claims File - Public Use Data Elements										
Order	**Element**	**Data Element Name**	**Max Length**	**Data Type Guide**	**Description**	**Release Notes**	**Edit Level**	**APCD Threshold**	**Public / Restricted**	**Masked**
41	MC058	ICD9-CM Procedure Code	6	varchar	ICD Primary Procedure Code (External Code Source 5)	Primary ICD-9 procedure code. The Integer point is not coded. The ICD-9 procedure must be repeated for all lines of the claim if necessary. Required for inpatient institutional claims.	A2	66%	P	No
42	MC061	Quantity	10	int	Claim line units of service	Count of services/units performed.	A1	98%	P	No
43	MC062	Charge Amount	19	money	Amount of provider charges for the claim line	The amount the provider charged for the claim line service.	A0	99%	P	No
44	MC063	Paid Amount	19	money	Amount paid by the carrier for the claim line	The amount paid to the provider for this claim line.	A0	99%	P	No
45	MC064	Prepaid Amount	19	money	Amount carrier has pre-paid towards claim line	The amount the carrier or its designee has pre-paid towards a claim line.	B	99%	P	No
46	MC065	Copay Amount	19	money	Amount of Copay member/patient is responsible to pay	The copay amount applied to a claim line or full claim as calculated by the carrier or its designee.	A1	99%	P	No
47	MC066	Coinsurance Amount	19	money	Amount of coinsurance member/patient is responsible to pay	The coinsurance amount applied to a claim line or full claim as calculated by the carrier or its designee.	A1	99%	P	No
48	MC067	Deductible Amount	19	money	Amount of deductible member/patient is responsible to pay on the claim line	The deductible amount applied to a claim line or full claim as calculated by the carrier or its designee.	A1	99%	P	No
49	MC070	Service Provider Country Code	30	varchar	Country name of the Provider. Data requirement is a 3 digit code (External Code Source 1 (ISO 3166-1, alpha-3)).	Country of the Service Provider.	C	98%	P	No
50	MC071	DRG	10	varchar	Diagnostic Related Group (DRG) Code (External Code Source 11)	CMS methodology when available. When the CMS methodology for DRGs is not available, but the All Payer DRG system is used, the insurer shall format the DRG and the complexity level within the same field with an “A” prefix, and with a hyphen separating the DRG and the complexity level (e.g. AXXX-XX).	B	20%	P	No

Medical Claims File - Public Use Data Elements										
Order	**Element**	**Data Element Name**	**Max Length**	**Data Type Guide**	**Description**	**Release Notes**	**Edit Level**	**APCD Threshold**	**Public / Restricted**	**Masked**
51	MC072	DRG Version	2	varchar	Diagnostic Related Group (DRG) Code Version Number (External Code Source 11)	Version identifier of the DRG Grouper used.	B	20%	P	No
52	MC073	APC	5	varchar	Ambulatory Payment Classification (APC) Number (External Code Source 16)	CMS APC methodology expected.	C	20%	P	No
53	MC074	APC Version	2	varchar	Ambulatory Payment Classification (APC) Version	Version identifier of the APC Grouper used	C	20%	P	No
54	MC075	Drug Code	11	varchar	National Drug Code (NDC)	A standard NDC Code as defined by the FDA in 5-4-2 format without hyphenation.	B	1%	P	No
55	MC077	National Billing Provider ID	256	Varbinary	National Provider Identification (NPI) of the Billing Provider (External Code Source 4)	The National Provider ID (NPI) of the Billing Provider.	B	99%	P	**Yes**
56	MC078	Billing Provider Last Name or Organization Name	60	varchar	Last name or Organization Name of Billing Provider	Last name, or Organization name, of the Billing Provider.	B	99%	P	No
57	MC081	Capitated Encounter Flag	1	varchar	Indicates if the service is covered under a capitation arrangement. (Lookup Table)	Numeric indicator that reports if a claim line is covered under a capitation arrangement.	A0	100%	P	No
58	MC083	Other ICD-9-CM Procedure Code - 1	6	varchar	ICD Secondary Procedure Code (External Code Source 5)	Second ICD-9 procedure code. The Integer point is not coded. The ICD-9 procedure must be repeated for all lines of the claim if necessary. Required for inpatient institutional claims.	C	1%	P	No
59	MC084	Other ICD-9-CM Procedure Code - 2	6	varchar	ICD Other Procedure Code (External Code Source 5)	Third ICD-9 procedure code. The Integer point is not coded. The ICD-9 procedure must be repeated for all lines of the claim if necessary. Required for inpatient institutional claims.	C	1%	P	No

Medical Claims File - Public Use Data Elements										
Order	**Element**	**Data Element Name**	**Max Length**	**Data Type Guide**	**Description**	**Release Notes**	**Edit Level**	**APCD Threshold**	**Public / Restricted**	**Masked**
60	MC085	Other ICD-9-CM Procedure Code - 3	6	varchar	ICD Other Procedure Code (External Code Source 5)	Fourth ICD-9 procedure code. The Integer point is not coded. The ICD-9 procedure must be repeated for all lines of the claim if necessary. Required for inpatient institutional claims.	C	1%	P	No
61	MC086	Other ICD-9-CM Procedure Code - 4	6	varchar	ICD Other Procedure Code (External Code Source 5)	Fifth ICD-9 procedure code. The Integer point is not coded. The ICD-9 procedure must be repeated for all lines of the claim if necessary. Required for inpatient institutional claims.	C	1%	P	No
62	MC087	Other ICD-9-CM Procedure Code - 5	6	varchar	ICD Other Procedure Code (External Code Source 5)	Sixth ICD-9 procedure code. The Integer point is not coded. The ICD-9 procedure must be repeated for all lines of the claim if necessary. Required for inpatient institutional claims.	C	1%	P	No
63	MC088	Other ICD-9-CM Procedure Code - 6	6	varchar	ICD Other Procedure Code (External Code Source 5)	Seventh ICD-9 procedure code. The Integer point is not coded. The ICD-9 procedure must be repeated for all lines of the claim if necessary. Required for inpatient institutional claims.	C	1%	P	No
64	MC089	Paid Date	23	datetime	Paid date of the claim line	The date that appears on the check and/or remit and/or explanation of benefits and corresponds to any and all types of payment for this claim line (Claims paid in full, partial or zero paid). This can be the same date as Processed Date. (YYYY-MM-DD 00:00:00.000)	A0	98%	P	No
65	MC090	LOINC Code	7	varchar	Logical Observation Identifiers, Names and Codes (LOINC) Code	The Logical Observation Identifiers, Names and Code for laboratory test / results for the claim line.	B	0%	P	No
66	MC092	Covered Days	10	int	Covered Inpatient Days	Amount of inpatient days paid for by the carrier. If not available, the number of days authorized by the carrier for the admission.	B	80%	P	No

Medical Claims File - Public Use Data Elements										
Order	**Element**	**Data Element Name**	**Max Length**	**Data Type Guide**	**Description**	**Release Notes**	**Edit Level**	**APCD Threshold**	**Public / Restricted**	**Masked**
67	MC093	Non Covered Days	10	int	Noncovered Inpatient Days	Amount of inpatient days that were not paid for by the plan for the inpatient event. Enter 0 when not applicable.	B	80%	P	No
68	MC094	Type of Claim	3	varchar	Type of Claim Indicator (Lookup Table)	Numeric indicator of the type of claim received and processed by the carrier or its designee (Professional, Hospital, or Reimbursement Form).	A0	100%	P	No
69	MC095	Coordination of Benefits/TPL Liability Amount	19	money	Amount due from a Secondary Carrier when known	The amount that another carrier/insurer is liable for, as determined by the carrier or its designee after their adjudication.	B	0%	P	No
70	MC096	Other Insurance Paid Amount	19	money	Amount paid by a Primary Carrier	The amount that another carrier paid for this claim line.	A2	90%	P	No
71	MC097	Medicare Paid Amount	19	money	Amount Medicare paid on claim	The amount that Medicare paid towards this claim line prior to carrier adjudication.	B	98%	P	No
72	MC099	Non-Covered Amount	19	money	Amount of claim line charge not covered	The amount that the carrier or its designee has determined to be above the plan limitations on this claim line.	B	98%	P	No
73	MC108	Procedure Modifier - 3	2	varchar	HCPCS / CPT Code Modifier	The third modifier for the procedure code reported on this claim line.	C	0%	P	No
74	MC109	Procedure Modifier - 4	2	varchar	HCPCS / CPT Code Modifier	The fourth modifier for the procedure code reported on this claim line.	C	0%	P	No
75	MC111	Diagnostic Pointer	1	varchar	Diagnostic Pointer Number	A numeric indicator that aligns each claim line service to a diagnosis: 1 for Principal Diagnosis; 2 for Other Diagnosis-1; 3 for Other Diagnosis-2, etc.	B	90%	P	No
76	MC113	Payment Arrangement Type	2	varchar	Payment Arrangement Code (Lookup Table)	Numeric indicator that reports how the payment was derived for the claim line by the carrier or its designee.	A0	90%	P	No

Medical Claims File - Public Use Data Elements										
Order	**Element**	**Data Element Name**	**Max Length**	**Data Type Guide**	**Description**	**Release Notes**	**Edit Level**	**APCD Threshold**	**Public / Restricted**	**Masked**
77	MC114	Excluded Expenses	19	money	Amount not covered at the claim line due to benefit/plan limitation	The amount that a carrier or its designee has determined to be over the plan limitations for Patient utilization.	B	80%	P	No
78	MC115	Medicare Indicator	1	varchar	Medicare Payment Indicator (Lookup Table)	Numeric indicator that reports if the claim line has any Medicare payments applied towards it as a Prior Payer on the claim.	A0	100%	P	No
79	MC116	Withhold Amount	19	money	Amount to be paid to the provider upon guarantee of performance	The amount paid to the provider for this service if the provider qualifies / meets performance guarantees.	B	80%	P	No
80	MC117	Authorization Needed	1	varchar	Indicates if the service required a pre-authorization number for payment. (Lookup Table)	Numeric indicator that reports if a claim line requires an authorization by the carrier or its designee.	B	100%	P	No
81	MC118	Referral Indicator	1	varchar	Referral Required Indicator (Lookup Table)	Numeric indicator that reports if a claim line requires a referral by the carrier or its designee.	A0	100%	P	No
82	MC119	PCP Indicator	1	varchar	PCP Service Performance Indicator (Lookup Table)	Numeric indicator that reports if a claim line was performed by the Patient's assigned Primary Care Provider.	B	100%	P	No
83	MC120	DRG Level	3	varchar	Diagnostic Related Group (DRG) Code Level (External Code Source 11)	Severity adjustment level when applicable.	B	80%	P	No
84	MC122	Global Payment Flag	1	varchar	Global Payment Method Indicator (Lookup Table)	Numeric indicator that reports if a claim line was processed / paid under a global payment arrangement.	A0	100%	P	No
85	MC123	Denied Flag	1	varchar	Denied Claim Line Indicator (Lookup Table)	Numeric indicator that reports if the claim line was denied by the claims processor.	A0	100%	P	No
86	MC126	Accident Indicator	1	varchar	Service is related to an accident (Lookup Table)	Numeric indicator that reports if the claim line procedure was performed due to an accident (not employment based).	B	100%	P	No
87	MC127	Family Planning Indicator	1	varchar	Service is related to Family Planning (Lookup Table)	Numeric indicator that reports the claim line service's relation to family planning.	B	90%	P	No

Medical Claims File - Public Use Data Elements										
Order	**Element**	**Data Element Name**	**Max Length**	**Data Type Guide**	**Description**	**Release Notes**	**Edit Level**	**APCD Threshold**	**Public / Restricted**	**Masked**
88	MC128	Employment Related Indicator	1	varchar	Service related to Employment Injury (Lookup Table)	Numeric indicator that reports if the claim line procedure was performed due to an employment related accident.	B	100%	P	No
89	MC129	EPSDT Indicator	1	varchar	Service related to Early Periodic Screening, Diagnosis and Treatment (EPSDT) (Lookup Table)	Numeric indicator that reports the claim line service's relation to EPSDT services.	B	90%	P	No
90	MC130	Procedure Code Type	1	varchar	Claim line Procedure Code Type Identifier (Lookup Table)	Numeric indicator that reports the type of procedure code expected on this claim line.	A1	80%	P	No
91	MC131	InNetwork Indicator	1	varchar	Network rates applied identifier (Lookup Table)	Numeric indicator that reports if a claim line was processed / paid at In-Network rates.	B	100%	P	No
92	MC132	Service Class	2	varchar	Service Class Code (Carrier Defined Reference Table)	A code used to define Behavioral Health services to MassHealth and MassHealth Managed Care Organization patients.	C	10%	P	No
93	MC136	Discharge Diagnosis	7	varchar	ICD Discharge Diagnosis Code (External Code Source 5)	The ICD9 diagnosis code assigned to the Patient upon discharge.	B	80%	P	No
94	MC138	Claim Line Type	10	varchar	Claim Line Activity Type Code (Lookup Table)	A code that reports the final outcome of the claim line during the submission period of the carrier or its designee. Example: Original, Void, Replacement, Back Out, Amendment	A0	90%	P	No
95	MC899	Record Type	2	varchar	File Type Identifier	The APCD filing-type identifier that defines the data contained within the file.	A0	100%	P	No
96	MC001 / MC024	Payer / Service Provider Number	256	varbinary	Submitter Org ID as defined by DHCFP/ Service Provider Identification Number	Combined Payer/ Service Provider ID for de-identified linking. Masked value. Can be linked to Masked value in elements with the same combined ID values.			P	Yes
97	MC001 / MC032	Payer/Service Provider Specialty	256	varbinary	Submitter Org ID as defined by DHCFP/ Service Provider Specialty Code (as defined by Carrier)	Combined Payer/ Specialty Code for de-identified linking. Use this Masked field value to link to the code Description in the Carrier-Specific Master Lookup Table			P	Yes

Medical Claims File - Public Use Data Elements										
Order	**Element**	**Data Element Name**	**Max Length**	**Data Type Guide**	**Description**	**Release Notes**	**Edit Level**	**APCD Threshold**	**Public / Restricted**	**Masked**
98	MC001 / MC076	Payer / Billing Provider Number	256	varbinary	Submitter Org ID as defined by DHCFP/ Billing Provider Number	Combined Payer/ Billing Provider ID for de-identified linking. Masked value. Can be linked to Masked value in elements with the same combined ID values.			P	Yes
99	MC001 / MC079	Payer / Product ID Number	256	varbinary	Submitter Org ID as defined by DHCFP/ Product Identification Number	Combined Payer/ Product ID for de-identified linking. Masked value. Can be linked to Masked value in elements with the same combined ID values.			P	Yes
100	MC001 / MC100	Payer / Delegated Benefit Administrator Organization ID	256	varbinary	Submitter Org ID as defined by DHCFP/ DHCFP assigned Org ID for Delegated Benefit Administrator	Combined Payer/ DBA ID for de-identified linking. Masked value. Can be linked to Masked value in elements with the same combined ID values.			P	Yes
101	MC001 / MC112	Payer / Referring Provider ID	256	varbinary	Submitter Org ID as defined by DHCFP/ Referring Provider Number	Combined Payer/ Referring Provider ID for de-identified linking. Masked value. Can be linked to Masked value in elements with the same combined ID values.			P	Yes
102	MC001 / MC125	Payer / Attending Provider	256	varbinary	Submitter Org ID as defined by DHCFP/ Attending Provider ID number found in the Provider File (PV002). This number is defined in the carrier's systems and may be equal to any other identifier, i.e., NPI, State License Number	Combined Payer/ Attending Provider ID for de-identified linking. Masked value. Can be linked to Masked value in elements with the same combined ID values.			P	Yes
103	MC001 / MC132	Payer / Service Class	256	varbinary	Submitter Org ID as defined by DHCFP/ Service Class Code (as defined by Carrier)	Combined Payer/ Service Class Code for de-identified linking. Use this Masked field value to link to the code Description in the Carrier-Specific Master Lookup Table			P	Yes
104	MC001 / MC134	Payer / Plan Rendering Provider Identifier	256	varbinary	Submitter Org ID as defined by DHCFP/ Plan Rendering Provider ID	Combined Payer/ Rendering Provider ID for de-identified linking. Masked value. Can be linked to Masked value in elements with the same combined ID values.			P	Yes

Medical Claims File - Public Use Data Elements										
Order	**Element**	**Data Element Name**	**Max Length**	**Data Type Guide**	**Description**	**Release Notes**	**Edit Level**	**APCD Threshold**	**Public / Restricted**	**Masked**
105	MC001 / MC135	Payer / Provider Location	256	varbinary	Submitter Org ID as defined by DHCFP / Location of Provider	Combined Payer/ Provider Location for de-identified linking. Masked value. Can be linked to Masked value in elements with the same combined ID values.			P	Yes
106	MC001 / MC137	Payer / CarrierSpecificUniqueMemberID	256	varbinary	Submitter Org ID as defined by DHCFP/ Carrier-assigned Member/Patient Unique ID	Combined Payer/ Member ID for de-identified linking. Masked value. Can be linked to Masked value in elements with the same combined ID values.			P	Yes
107	MC001 / MC141	Payer / CarrierSpecificUniqueSubscriberID	256	varbinary	Submitter Org ID as defined by DHCFP/ Subscriber Carrier Unique Identification	Combined Payer/ Subscriber ID for de-identified linking. Masked value. Can be linked to Masked value in elements with the same combined ID values.			P	Yes
108	Derived by DHCFP	Final Version Flag	5	varchar	Claim Line Final Version Flag - Derived by DHCFP in Versioning Process	Process sets to Highest Version any claim that is not a void or back out, not voided, not replaced, not a duplicate and where the Claim Status is not 04 (Denied) or 22 (Reversal). Claim Line Type may be Original, Replacement, or Amendment. ("True" or "False" indicate whether the claim line is a Final Version)			P	No
109	Derived by DHCFP	Unique Record ID: Public File	10	int	Unique Record ID - Derived by DHCFP	Unique Record ID for Medical Claim: Restricted File value matches Public File value for the same Claim Line.			P	No

Medical Claims File - Restricted Use Data Elements										
Order	**Element**	**Data Element Name**	**Max Length**	**Data Type Guide**	**Description**	**Release Notes**	**Edit Level**	**APCD Threshold**	**Public / Restricted**	**Masked**
1	MC001	Payer	256	varbinary	Carrier Specific Submitter Code as defined by APCD.	A Division assigned identifier for any APCD Data Submitter; Insurance, Benefit Manager/Administrator, TPA, Vendor	A0	100%	R	Yes

Medical Claims File - Restricted Use Data Elements										
Order	**Element**	**Data Element Name**	**Max Length**	**Data Type Guide**	**Description**	**Release Notes**	**Edit Level**	**APCD Threshold**	**Public / Restricted**	**Masked**
2	MC002	National Plan ID	256	varbinary	CMS National Plan Identification Number (PlanID)	Unique identifier as outlined by Centers for Medicare and Medicaid Services (CMS) for Plans.	Z	0%	R	Yes
3	MC003	Insurance Type Code/Product	256	varbinary	Type / Product Identification Code (Lookup Table)	A code that defines the type of insurance applied to the claim line. This value can be derived from the claim as submitted by the provider or reassigned by the carrier or its designee.	C	92%	R	Yes
4	MC004	Payer Claim Control Number	256	varbinary	Payer Claim Control Identification	Unique identifier within the payer's system that applies to the entire claim.	A0	100%	R	Yes
5	MC006	Insured Group or Policy Number	256	varbinary	Carriers group or policy number	The carrier assigned group / policy number for this claim line. This information is often filed as reported by the provider.	C	95%	R	Yes
6	MC011	Individual Relationship Code	2	varchar	Member/Patient to Subscriber Relationship Code (Lookup Table)	Numeric indicator to define the Patient's relationship to the Subscriber. This value can be derived from the claim as submitted by the provider or reassigned by the carrier or its designee.	B	98%	R	No
7	MC013/ Month	Member Birth Month		int	Member/Patient's date of birth - Month Only (Derived by DHCFP)	Integer indicating the Birth Month of the Patient.			R	No
8	MC014	Member City Name	128	varchar	City name of the Member/Patient	City of the Patient.	B	98%	R	No
9	MC016/First3	First 3 of Member zip code	3	varchar	Zip Code of the Member/Patient - First 3 digits (Derived by DHCFP)	First three digits of the Zip Code of the Patient.			R	No
10	MC017	Date Service Approved (AP Date)	23	datetime	Date Service Approved	The date the service was approved for payment by the carrier or its designee. (YYYY-MM-DD 00:00:00.000)	C	93%	R	No

Medical Claims File - Restricted Use Data Elements										
Order	**Element**	**Data Element Name**	**Max Length**	**Data Type Guide**	**Description**	**Release Notes**	**Edit Level**	**APCD Threshold**	**Public / Restricted**	**Masked**
11	MC018	Admission Date	23	datetime	Inpatient Admit Date	The date that the Patient was admitted into an inpatient setting at the facility. (YYYY-MM-DD 00:00:00.000)	A1	98%	R	No
12	MC018/ Month	Admission Month	10	int	Inpatient Admit Date - Month only	Month of the date that the Patient was admitted into an inpatient setting at the facility.			R	No
13	MC018/Year	Admission Year	10	int	Inpatient Admit Date - Year only	Year of the date that the Patient was admitted into an inpatient setting at the facility.			R	No
14	MC019	Admission Hour	4	varchar	Admission Time	The admission time of the Patient into an inpatient setting/facility and reported in military time.	C	5%	R	No
15	MC022	Discharge Hour	4	varchar	Discharge Time	The discharge/transfer time of the Patient from the inpatient setting/facility and reported in military time.	C	5%	R	No
16	MC024	Service Provider Number	256	varbinary	Service Provider Identification Number	Link to PV002 on Provider File to obtain detailed attributes of the Service Provider.	A1	99%	R	Yes
17	MC025	Service Provider Tax ID Number	256	varbinary	Service Provider's Tax ID number	Tax ID of the Service Provider.	C	97%	R	Yes
18	MC059	Date of Service - From	23	datetime	Date of Service	The first date of service for the claim line. Inpatient claims may or may not repeat this date on all lines. (YYYY-MM-DD 00:00:00.000)	A0	98%	R	No
19	MC059/ Month	Date of Service - From Month	10	int	Date of Service - From Month only (Derived by DHCFP)	Month of the first date of service for the claim line. Inpatient claims may or may not repeat this date on all lines.			R	No
20	MC059/Year	Date of Service - From Year	10	int	Date of Service - From Year only (Derived by DHCFP)	Year of the first date of service for the claim line. Inpatient claims may or may not repeat this date on all lines.			R	No

Medical Claims File - Restricted Use Data Elements										
Ord-er	**Element**	**Data Element Name**	**Max Length**	**Data Type Guide**	**Description**	**Release Notes**	**Edit Level**	**APCD Thres-hold**	**Public / Restrict -ed**	**Mask-ed**
21	MC060	Date of Service - To	23	datetime	Date of Service	The last date of Service for the claim line. Inpatient claims may or may not repeat this date on all lines. (YYYY-MM-DD 00:00:00.000)	A0	98%	R	No
22	MC060/ Month	Date of Service - To Month	10	int	Date of Service - To Month only	Month of the last date of Service for the claim line. Inpatient claims may or may not repeat this date on all lines.			R	No
23	MC060/Y ear	Date of Service - To Year	10	int	Date of Service - To Year only	Year of the last date of Service for the claim line. Inpatient claims may or may not repeat this date on all lines.			R	No
24	MC068	Patient Control Number	256	varbinary	Patient Control Number	The encounter/visit number assigned by the provider to identify Patient treatment at a facility.	A2	10%	R	Yes
25	MC069	Discharge Date	23	datetime	Discharge Date	The date the Member was discharged from the inpatient facility. Inpatient claims may or may not repeat this date on all lines. (YYYY-MM-DD 00:00:00.000)	B	98%	R	No
26	MC069/ Month	Discharge Month	10	int	Discharge Date - Month only	Month of the date the Member was discharged from the inpatient facility. Inpatient claims may or may not repeat this date on all lines.			R	No
27	MC069/Y ear	Discharge Year	10	int	Discharge Date - Year only	Year of the date the Member was discharged from the inpatient facility. Inpatient claims may or may not repeat this date on all lines.			R	No
28	MC076	Billing Provider Number	256	varbinary	Billing Provider Number	Link to PV002 on the Provider File to obtain detailed attributes of the Billing Provider.	B	99%	R	Yes
29	MC079	Product ID Number	256	varbinary	Product Identification Number	Link to PR001 on the Product File to obtain detailed attributes of the Product to which this claim line's member eligibility is associated.	A0	100%	R	Yes

Medical Claims File - Restricted Use Data Elements										
Order	**Element**	**Data Element Name**	**Max Length**	**Data Type Guide**	**Description**	**Release Notes**	**Edit Level**	**APCD Threshold**	**Public / Restricted**	**Masked**
30	MC080	Reason for Adjustment	256	varbinary	Reason for Adjustment Code (Carrier Specific Lookup Table)	A code that reports the how the claim was processed for adjudication: describes the reason for the claims adjustment. Carriers shall submit a list of codes and descriptions for this field. NOTE: Description withheld by DHCFP pending data cleansing.	A1	80%	R	Yes
31	MC098	Allowed amount	19	money	Allowed Amount	The maximum amount contractually allowed and payable for this claim line as defined by the carrier or its designee.	A2	99%	R	No
32	MC100	Delegated Benefit Administrator Organization ID	256	varbinary	DHCFP assigned Org ID for Benefit Administrator	Linking ID used by carriers to identify their Benefit Administrators / Managers, Vendors, etc. This value is a Division assigned identifier.	C	0%	R	Yes
33	MC110	Claim Processed Date	23	datetime	Claim Processed Date	The date the claim was processed by the carrier or its designee for adjudication. (YYYY-MM-DD 00:00:00.000)	C	98%	R	No
34	MC112	Referring Provider ID	256	varbinary	Referring Provider Number	Link to PV002 on the Provider File to obtain detailed attributes of the Referring Provider.	B	98%	R	Yes
35	MC124	Denial Reason	256	varbinary	Denial Reason Code	The Claim Line denial reason as assigned by the carrier or its designee.	B	80%	R	Yes
36	MC125	Attending Provider	256	varbinary	Attending Provider ID number found in the Provider File (PV002). This number is defined in the carrier's systems and may be equal to any other identifier, i.e., NPI, State License Number	Link to PV002 on the Provider File to obtain detailed attributes of the Attending Provider as defined at a facility.	A1	98%	R	Yes

Medical Claims File - Restricted Use Data Elements										
Order	**Element**	**Data Element Name**	**Max Length**	**Data Type Guide**	**Description**	**Release Notes**	**Edit Level**	**APCD Threshold**	**Public / Restricted**	**Masked**
37	MC134	Plan Rendering Provider Identifier	256	varbinary	Plan Rendering Number	Link to PV002 on the Provider File to obtain detailed attributes of the Rendering Provider. This code identifies the actual individual that performed the service at the location reported via Provider Location.	A0	100%	R	Yes
38	MC135	Provider Location	256	varbinary	Location of Provider	Link to PV002 on the Provider File to obtain detailed attributes of the Provider Location. This code identifies the location/site where the service was performed by the Provider ID reported in Plan Rendering Provider Identifier.	B	98%	R	Yes
39	MC137	CarrierSpecificUniqueMemberID	256	varbinary	Member/Patient Carrier Unique Identification	Unique, internal identification assigned by the carrier or its designee to the Member. This can be used to link Claim Lines to eligibility segments.	A0	100%	R	Yes
40	MC141	CarrierSpecificUniqueSubscriberID	256	varbinary	Subscriber Carrier Unique Identification	Unique, internal identification assigned by the carrier or its designee to the Subscriber. This can be used to link Claim Lines to eligibility segments.	A0	100%	R	Yes
41	MC001 / MC080	Payer / Reason for Adjustment	256	varbinary	Submitter Org ID as defined by DHCFP/ Reason for Adjustment Code (as defined by Carrier)	Use this Masked field value to link to the code Description in the Carrier-Specific Master Lookup Table. **NOTE: Description redacted for 10/31/2012 release due to confidentiality issue.**			R	Yes
42	MC001 / MC124	Payer / Denial Reason	256	varbinary	Submitter Org ID as defined by DHCFP/ Denial Reason Code (as defined by Carrier)	Use this Masked field value to link to the code Description in the Carrier-Specific Master Lookup Table. **NOTE: Description redacted for 10/31/2012 release due to confidentiality issue.**			R	Yes
43	Derived by DHCFP	Unique Record ID: Restricted File	10	int	Unique Record ID - Derived by DHCFP	Unique Record ID for Medical Claim: Restricted File value matches Public File value for the same Claim Line.			R	No

Medical Claims File - Unavailable Data Elements							
Order	**Element**	**Data Element Name**	**Description**	**Release Notes**	**Edit Level**	**APCD Threshold**	**Public / Restricted**
1	MC007	Subscriber SSN	Subscriber's Social Security Number	Tax ID of the Subscriber.	B	79%	not released
2	MC008	Plan Specific Contract Number	Plan Specific Contract Number	Plan assigned contract/certificate number for the Subscriber and all of the corresponding dependents. This identifier must not disclose individuals.	C	98%	not released
3	MC009	Member Suffix or Sequence Number	Member/Patient's Contract Sequence Number	A unique identifier that is assigned to each beneficiary under a contract.	B	98%	not released
4	MC010	Member SSN	Member/Patient's Social Security Number	Tax ID of the Patient.	B	73%	not released
5	MC013	Member Date of Birth	Member/Patient's date of birth	Birth date of the Patient.	B	98%	not released
6	MC016	Member ZIP Code	Zip Code of the Member/Patient	Zip Code of the Patient.	B	98%	not released
7	MC082	Member Street Address	Street address of the Member/Patient	Street address of the Patient.	B	90%	not released
8	MC101	Subscriber Last Name	Last name of Subscriber	Last name (or entity name) of the Subscriber.	B	98%	not released
9	MC102	Subscriber First Name	First name of the Subscriber	First name of Subscriber, when appropriate	B	98%	not released
10	MC103	Subscriber Middle Initial	Middle initial of Subscriber	Middle initial of the Subscriber, when appropriate.	C	2%	not released
11	MC104	Member Last Name	Last name of Member/Patient	Last name of the Member.	B	98%	not released

Medical Claims File - Unavailable Data Elements							
Order	**Element**	**Data Element Name**	**Description**	**Release Notes**	**Edit Level**	**APCD Threshold**	**Public / Restricted**
12	MC105	Member First Name	First name of Member/Patient	First name of the Patient.	B	98%	not released
13	MC106	Member Middle Initial	Middle initial of Member/Patient	Middle initial of the Patient.	C	2%	not released
14	MC139	Former Claim Number	Previous Claim Number	The Payer Claim Control Number previously assigned to this claim line in a prior reporting period.	B	0%	not released
15	MC140	Member Address 2	Secondary Street Address of the Member/Patient	Street address 2 of the Patient.	B	1%	not released

APCD Medical Claims File Lookup Tables, by Element										
Order	**Element**	**Data Element Name**	**Max Length**	**Data Type Guide**	**Description**	**Release Notes**	**Edit Level**	**APCD Threshold**	**Public / Restricted**	**Masked**
3	MC003	Insurance Type Code/Product	256	varbinary	Type / Product Identification Code (Lookup Table)	A code that defines the type of insurance applied to the claim line. This value can be derived from the claim as submitted by the provider or reassigned by the carrier or its designee.	C	92%	R	Yes
					Claim Insurance Type Code	***Claim Insurance Type***				
					09	Self-pay				
					10	Central Certification				
					11	Other Non-Federal Programs				
					12	Preferred Provider Organization (PPO)				
					13	Point of Service (POS)				
					14	Exclusive Provider Organization (EPO)				

APCD Medical Claims File Lookup Tables, by Element										
Ord-er	**Element**	**Data Element Name**	**Max Length**	**Data Type Guide**	**Description**	**Release Notes**	**Edit Level**	**APCD Thres-hold**	**Public / Restrict-ed**	**Mask-ed**
					15	Indemnity Insurance				
					16	Health Maintenance Organization (HMO) Medicare Risk				
					AM	Automobile Medical				
					BL	Blue Cross / Blue Shield				
					CC	Commonwealth Care				
					CE	Commonwealth Choice				
					CH	Champus				
					CI	Commercial Insurance Co.				
					DS	Disability				
					HM	Health Maintenance Organization				
					LI	Liability				
					LM	Liability Medical				
					MA	Medicare Part A				
					MB	Medicare Part B				
					MC	Medicaid				
					OF	Other Federal Program				
					TV	Title V				
					VA	Veterans Administration Plan				
					WC	Workers' Compensation				
6	MC011	Individual Relationship Code	2	varchar	Member/Patient to Subscriber Relationship Code (Lookup Table)	Numeric indicator to define the Patient's relationship to the Subscriber. This value can be derived from the claim as submitted by the provider or reassigned by the carrier or its designee.	B	98%	R	No
					Individual Relationship Code	***Individual Relationship***				

APCD Medical Claims File Lookup Tables, by Element										
Ord-er	**Element**	**Data Element Name**	**Max Length**	**Data Type Guide**	**Description**	**Release Notes**	**Edit Level**	**APCD Thres-hold**	**Public / Restrict-ed**	**Mask-ed**
					1	Spouse				
					4	Grandfather or Grandmother				
					5	Grandson or Granddaughter				
					7	Nephew or Niece				
					10	Foster Child				
					15	Ward				
					17	Stepson or Stepdaughter				
					19	Child				
					20	Self/Employee				
					21	Unknown				
					22	Handicapped Dependent				
					23	Sponsored Dependent				
					24	Dependent of a Minor Dependent				
					29	Significant Other				
					32	Mother				
					33	Father				
					36	Emancipated Minor				
					39	Organ Donor				
					40	Cadaver Donor				
					41	Injured Plaintiff				
					43	Child Where Insured Has No Financial Responsibility				
					53	Life Partner				
					76	Dependent				

APCD Medical Claims File Lookup Tables, by Element										
Order	**Element**	**Data Element Name**	**Max Length**	**Data Type Guide**	**Description**	**Release Notes**	**Edit Level**	**APCD Threshold**	**Public / Restricted**	**Masked**
3	MC012	Member Gender	1	varchar	Member/Patient's Gender (Lookup Table)	A code that defines the Patient's gender. This can be derived from the claim as submitted by the provider or reassigned by the carrier or its designee.	B	98%	P	No
					Gender Code	***Gender***				
					F	Female				
					M	Male				
					O	Other				
					U	Unknown				
10	MC027	Service Provider Entity Type Qualifier	1	varchar	Service Provider Entity Type Identifier Code (Lookup Table)	Numeric indicator to define the Service Provider as a **Person or Non-person.** This value drives various 'person' -type requirements; First Name, Date of Birth, Gender, etc.	A0	98%	P	No
					Service Provider Entity Type Qualifier Code	***Service Provider Entity Type Qualifier***				
					1	Person				
					2	Non-person entity				
14	MC031	Service Provider Suffix	10	varchar	Provider Name Suffix (Lookup Table)	The generational title of the provider when the Service Provider Entity Type = 1 (Person)	Z	2%	P	No
					Last Name Suffix ID	***Last Name Suffix***				
					0	Unknown / Not Applicable				
					1	I.				
					2	II.				
					3	III.				
					4	Jr.				
					5	Sr.				

APCD Medical Claims File Lookup Tables, by Element										
Order	**Element**	**Data Element Name**	**Max Length**	**Data Type Guide**	**Description**	**Release Notes**	**Edit Level**	**APCD Threshold**	**Public / Restricted**	**Masked**
21	MC038	Claim Status	2	varchar	Claim Line Status (Lookup Table)	Numeric indicator that reports if the claim line was paid by the carrier or its designee, and the COB order of the payment.	A0	98%	P	No
					Claim Status Code	***Claim Status***				
					01	Processed as primary				
					02	Processed as secondary				
					03	Processed as tertiary				
					04	Denied				
					19	Processed as primary, forwarded to additional payer(s)				
					20	Processed as secondary, forwarded to additional payer(s)				
					21	Processed as tertiary, forwarded to additional payer(s)				
					22	Reversal of previous payment				
57	MC081	Capitated Encounter Flag	1	varchar	Indicates if the service is covered under a capitation arrangement. (Lookup Table)	Numeric indicator that reports if a claim line is covered under a capitation arrangement.	A0	100%	P	No
					Value	***Description***				
					1	Yes				
					2	No				
					3	Unknown				
					4	Other				
					5	Not Applicable				
68	MC094	Type of Claim	3	varchar	Type of Claim Indicator (Lookup Table)	Numeric indicator of the type of claim received and processed by the carrier or its designee (Professional, Hospital, or Reimbursement Form).	A0	100%	P	No

APCD Medical Claims File Lookup Tables, by Element										
Order	**Element**	**Data Element Name**	**Max Length**	**Data Type Guide**	**Description**	**Release Notes**	**Edit Level**	**APCD Threshold**	**Public / Restricted**	**Masked**
					Type Of Claim Code	***Type Of Claim***				
					001	Professional				
					002	Hospital				
					003	Reimbursement Form				
76	MC113	Payment Arrangement Type	2	varchar	Payment Arrangement Code (Lookup Table)	Numeric indicator that reports how the payment was derived for the claim line by the carrier or its designee.	A0	90%	P	No
					Payment Arrangement Type Code	***Payment Arrangement Type***				
					01	Capitation				
					02	Fee for Service				
					03	Percent of Charges				
					04	DRG				
					05	Pay for Performance				
					06	Global Payment				
					07	Other				
78	MC115	Medicare Indicator	1	varchar	Medicare Payment Indicator (Lookup Table)	Numeric indicator that reports if the claim line has any Medicare payments applied towards it as a Prior Payer on the claim.	A0	100%	P	No
					Value	***Description***				
					1	Yes				
					2	No				
					3	Unknown				
					4	Other				
					5	Not Applicable				

APCD Medical Claims File Lookup Tables, by Element										
Ord-er	**Element**	**Data Element Name**	**Max Length**	**Data Type Guide**	**Description**	**Release Notes**	**Edit Level**	**APCD Thres-hold**	**Public / Restrict-ed**	**Mask-ed**
80	MC117	Authorizati on Needed	1	varchar	Indicates if the service required a pre-authorization number for payment. (Lookup Table)	Numeric indicator that reports if a claim line requires an authorization by the carrier or its designee.	B	100%	P	No
					Value	***Description***				
					1	Yes				
					2	No				
					3	Unknown				
					4	Other				
					5	Not Applicable				
81	MC118	Referral Indicator	1	varchar	Referral Required Indicator (Lookup Table)	Numeric indicator that reports if a claim line requires a referral by the carrier or its designee.	A0	100%	P	No
					Value	***Description***				
					1	Yes				
					2	No				
					3	Unknown				
					4	Other				
					5	Not Applicable				
82	MC119	PCP Indicator	1	varchar	PCP Service Performance Indicator (Lookup Table)	Numeric indicator that reports if a claim line was performed by the Patient's assigned Primary Care Provider.	B	100%	P	No
					Value	***Description***				
					1	Yes				
					2	No				
					3	Unknown				
					4	Other				
					5	Not Applicable				

APCD Medical Claims File Lookup Tables, by Element										
Ord-er	**Element**	**Data Element Name**	**Max Length**	**Data Type Guide**	**Description**	**Release Notes**	**Edit Level**	**APCD Thres-hold**	**Public / Restrict-ed**	**Mask-ed**
84	MC122	Global Payment Flag	1	varchar	Global Payment Method Indicator (Lookup Table)	Numeric indicator that reports if a claim line was processed / paid under a global payment arrangement.	A0	100%	P	No
					Value	***Description***				
					1	Yes				
					2	No				
					3	Unknown				
					4	Other				
					5	Not Applicable				
85	MC123	Denied Flag	1	varchar	Denied Claim Line Indicator (Lookup Table)	Numeric indicator that reports if the claim line was denied by the claims processor.	A0	100%	P	No
					Value	***Description***				
					1	Yes				
					2	No				
					3	Unknown				
					4	Other				
					5	Not Applicable				
86	MC126	Accident Indicator	1	varchar	Service is related to an accident (Lookup Table)	Numeric indicator that reports if the claim line procedure was performed due to an accident (not employment based).	B	100%	P	No
					Value	***Description***				
					1	Yes				
					2	No				
					3	Unknown				
					4	Other				
					5	Not Applicable				

APCD Medical Claims File Lookup Tables, by Element										
Order	**Element**	**Data Element Name**	**Max Length**	**Data Type Guide**	**Description**	**Release Notes**	**Edit Level**	**APCD Threshold**	**Public / Restricted**	**Masked**
87	MC127	Family Planning Indicator	1	varchar	Service is related to Family Planning (Lookup Table)	Numeric indicator that reports the claim line service's relation to family planning.	B	90%	P	No
					Family Planning Code	***Family Planning***				
					0	Unknown / Not Applicable / Not Avail				
					1	Family planning services provided				
					2	Abortion services provided				
					3	Sterilization services provided				
					4	No family planning services provided				
88	MC128	Employment Related Indicator	1	varchar	Service related to Employment Injury (Lookup Table)	Numeric indicator that reports if the claim line procedure was performed due to an employment related accident.	B	100%	P	No
					Value	***Description***				
					1	Yes				
					2	No				
					3	Unknown				
					4	Other				
					5	Not Applicable				
89	MC129	EPSDT Indicator	1	varchar	Service related to Early Periodic Screening, Diagnosis and Treatment (EPSDT) (Lookup Table)	Numeric indicator that reports the claim line service's relation to EPSDT services.	B	90%	P	No
					EPSDT Indicator Code	***EPSDT Indicator***				
					0	Unknown / Not Applicable / Not Avail				
					1	EPSDT Screen				
					2	EPSDT Treatment				
					3	EPSDT Referral				

APCD Medical Claims File Lookup Tables, by Element										
Order	**Element**	**Data Element Name**	**Max Length**	**Data Type Guide**	**Description**	**Release Notes**	**Edit Level**	**APCD Threshold**	**Public / Restricted**	**Masked**
90	MC130	Procedure Code Type	1	varchar	Claim line Procedure Code Type Identifier (Lookup Table)	Numeric indicator that reports the type of procedure code expected on this claim line.	A1	80%	P	No
					Procedure Code Type Code	***Procedure Code Type***				
					0	Carrier Custom Code				
					1	CPT or HCPCS Level 1 Code				
					2	HCPCS Level II Code				
					3	HCPCS Level III Code (State Medicare code).				
					4	American Dental Association (ADA) Procedure Code (Also referred to as CDT code.)				
					5	State defined Procedure Code				
91	MC131	InNetwork Indicator	1	varchar	Network rates applied identifier (Lookup Table)	Numeric indicator that reports if a claim line was processed / paid at In-Network rates.	B	100%	P	No
					Value	***Description***				
					1	Yes				
					2	No				
					3	Unknown				
					4	Other				
					5	Not Applicable				
94	MC138	Claim Line Type	10	varchar	Claim Line Activity Type Code (Lookup Table)	A code that reports the final outcome of the claim line during the submission period of the carrier or its designee. Example: Original, Void, Replacement, Back Out, Amendment	A0	90%	P	No
					Claim Line Type Code	***Claim Line Type***				
					O	Original				
					V	Void				

APCD Medical Claims File Lookup Tables, by Element										
Ord-er	**Element**	**Data Element Name**	**Max Length**	**Data Type Guide**	**Description**	**Release Notes**	**Edit Level**	**APCD Thres-hold**	**Public / Restrict-ed**	**Mask-ed**
					R	Replacement				
					B	Back Out				
					A	Amendment				

Medical Claims File: External Code Sources

Refer to Appendix 2 in this document: External Code Sources

The APCD Dental Claims File

Dental Claims - Public Use Data Elements										
Order	**Element**	**Data Element Name**	**Max Length**	**Data Type Guide**	**Description**	**Release Notes**	**Edit Level**	**APCD Threshold**	**Public / Restricted**	**Masked**
1	DC005	Line Counter	10	int	Incremental Line Counter	The line number for this service on the claim. First line should start with 1 and each additional line incremented by 1.	A0	100%	P	No
2	DC005A	Version Number	10	int	Claim Service Line Version Number	Incrementing counter for a claim line that is reprocessed for any reason over the course of time. Highest value should indicate latest reprocessing of line by the carrier/submitter.	A0	100%	P	No
3	DC012	Member Gender	1	varchar	Member/Patient's Gender (Lookup Table)	A code that defines the Patient's gender. This can be derived from the claim as submitted by the provider or reassigned by the carrier or its designee.	B	100%	P	No
4	DC013/ Year	Member Birth Year	10	int	Member/Patient's date of birth - Year only	Year of the Birth date of the Patient. Member Birth Year is reported as "999" when the Member is age 90 or older as of the Date of Service From date.	B		P	No
5	DC015	Member State or Province	2	varchar	State of the Member/Patient (External Code Source 2)	State of the Patient.	B	99%	P	No
6	DC020	National Service Provider ID	256	varbinary	National Provider Identification (NPI) of the National Service Provider (External Code Source 4)	The National Provider ID (NPI) of the Service Provider.	C	98%	P	Yes
7	DC021	Service Provider Entity Type Qualifier	1	varchar	Service Provider Entity Identifier Code (Lookup Table)	Numeric indicator to define the Service Provider as a person or non-person. This value drives various 'person' -type requirements; First Name, Date of Birth, Gender, etc.	A0	98%	P	No
8	DC022	Service Provider First Name	25	varchar	First name of Service Provider	First name of the Service Provider, when appropriate.	C	98%	P	No

Dental Claims - Public Use Data Elements										
Order	**Element**	**Data Element Name**	**Max Length**	**Data Type Guide**	**Description**	**Release Notes**	**Edit Level**	**APCD Threshold**	**Public / Restricted**	**Masked**
9	DC023	Service Provider Middle Name	25	varchar	Middle initial of Service Provider	Middle name / initial of the Service Provider when appropriate.	C	2%	P	No
10	DC024	Service Provider Last Name or Organization Name	60	varchar	Last name or Organization Name of Service Provider	Last name, or Organization name, of the Service Provider.	B	98%	P	No
11	DC026	Service Provider Specialty	10	varchar	Specialty Code (External Code Source 13 - AND/OR - Carrier Defined Reference Table)	A standardized taxonomy code (External Code Source 13) OR a carrier-defined specialty code of the Servicing Provider (APCD Master Lookup Table). Value is required to be in carrier-defined table if provided.	B	98%	P	No
12	DC027	Service Provider City Name	30	varchar	City name of the Provider	City of the Service Provider.	B	98%	P	No
13	DC028	Service Provider State	2	varchar	State of the Service Provider (External Code Source 2)	State of the Service Provider.	B	98%	P	No
14	DC029	Service Provider ZIP Code	5	varchar	Zip Code of the Service Provider (External Code Source 3)	Zip Code of the Service Provider.	B	98%	P	No
15	DC030	Facility Type - Professional	2	varchar	Place of Service Code as used on Professional Claims (External Code Source 9)	For Professional Claims, a standardized code that reports the type of facility where the claim line service occurred.	B	80%	P	No
16	DC031	Claim Status	2	varchar	Claim Line Status (Lookup Table)	Numeric indicator that reports if the claim line was paid by the carrier or its designee, and the COB order of the payment.	A0	90%	P	No
17	DC032	CDT Code	5	varchar	HCPCS / CDT Code (External Code Source 8)	The procedure code reported for this claim line.	A2	99%	P	No

Dental Claims - Public Use Data Elements										
Order	**Element**	**Data Element Name**	**Max Length**	**Data Type Guide**	**Description**	**Release Notes**	**Edit Level**	**APCD Threshold**	**Public / Restricted**	**Masked**
18	DC033	Procedure Modifier - 1	2	varchar	HCPCS / CPT Code Modifier (External Code Source 8)	The first modifier for the procedure code reported on this claim line.	C	0%	P	No
19	DC034	Procedure Modifier - 2	2	varchar	HCPCS / CPT Code Modifier (External Code Source 8)	The second modifier for the procedure code reported on this claim line.	C	0%	P	No
20	DC037	Charge Amount	19	money	Amount of provider charges for the claim line	Amount provider charged for the claim line service.	A0	99%	P	No
21	DC038	Paid Amount	19	money	Amount paid by the carrier for the claim line	The amount paid to the provider for this claim line.	A0	99%	P	No
22	DC039	Copay Amount	19	money	Amount of Copay member/patient is responsible to pay	The copay amount applied to a claim line or full claim as calculated by the carrier or its designee.	A1	99%	P	No
23	DC040	Coinsurance Amount	19	money	Amount of coinsurance member/patient is responsible to pay	The coinsurance amount applied to a claim line or full claim as calculated by the carrier or its designee.	A1	99%	P	No
24	DC041	Deductible Amount	19	money	Amount of deductible member/patient is responsible to pay on the claim line	The deductible amount applied to a claim line or full claim as calculated by the carrier or its designee.	A1	99%	P	No
25	DC045	Paid Date	23	Datetime	Paid date of the claim line	The date that appears on the check and/or remit and/or explanation of benefits, and corresponds to any and all types of payment for this claim line. (Paid in full, partial, and/or zero paid.) This can be the same date as Processed Date. (YYYY-MM-DD 00:00:00.000)	A0	98%	P	No
26	DC047	Tooth Number/Letter	20	varchar	Tooth Number or Letter Identification (External Code Source 8)	Standard enumeration of tooth when appropriate for the service provided.	C	80%	P	No
27	DC048	Dental Quadrant	1	varchar	Dental Quadrant (External Code Source 8)	Standard identification of oral quadrants when appropriate for the service provided.	C	80%	P	No

Dental Claims - Public Use Data Elements										
Order	**Element**	**Data Element Name**	**Max Length**	**Data Type Guide**	**Description**	**Release Notes**	**Edit Level**	**APCD Threshold**	**Public / Restricted**	**Masked**
28	DC049	Tooth Surface	10	varchar	Tooth Service Identification (External Code Source 8)	Standard identification of tooth surface(s) when appropriate for the service provided.	C	80%	P	No
29	DC059	Claim Line Type	10	varchar	Claim Line Activity Type Code (Lookup Table)	A code that reports the final outcome of the claim line during the submission period of the carrier or its designee. Example: Original, Void, Replacement, Back Out, Amendment.	A0	80%	P	No
30	DC899	Record Type	2	varchar	File Type Identifier	The APCD filing-type identifier that defines the data contained within the file.	A0	100%	P	No
31	DC001 / DC018	Payer / Service Provider Number	256	varbinary	Submitter Org ID as defined by DHCFP/ Service Provider Identification Number	Combined Payer/ Provider ID for de-identified linking. Masked value. Can be linked to masked value in elements with the same combined ID values.			P	Yes
32	DC001 / DC025	Payer / Delegated Benefit Administrator Organization ID	256	varbinary	Submitter Org ID as defined by DHCFP/ DHCFP assigned Org ID for Benefit Administrator	Combined Payer/ DBA ID for de-identified linking. Masked value. Can be linked to masked value in elements with the same combined ID values.			P	Yes
33	DC001 / DC026	Payer / Service Provider Specialty	256	varbinary	Submitter Org ID as defined by DHCFP/ Service Provider Specialty Code (as defined by Carrier)	Use this masked field value to link to the code Description in the **Carrier-Specific Master Lookup Table**			P	Yes
34	DC001 / DC042	Payer / Product ID Number	256	varbinary	Submitter Org ID as defined by DHCFP/ Product Identification Number	Combined Payer/ Product ID for de-identified linking. Masked value. Can be linked to masked value in elements with the same combined ID values.			P	Yes
35	DC001 / DC056	Payer / CarrierSpecificUniqueMemberID	256	varbinary	Submitter Org ID as defined by DHCFP/ Carrier-assigned Member/Patient Unique ID	Combined Payer/ Member ID for de-identified linking. Masked value. Can be linked to masked value in elements with the same combined ID values.			P	Yes

Dental Claims - Public Use Data Elements										
Order	**Element**	**Data Element Name**	**Max Length**	**Data Type Guide**	**Description**	**Release Notes**	**Edit Level**	**APCD Threshold**	**Public / Restricted**	**Masked**
36	DC001 / DC057	Payer / CarrierSpecificUniqueSubscriberID	256	varbinary	Submitter Org ID as defined by DHCFP/ Subscriber Carrier Unique Identification	Combined Payer/ Subscriber ID for de-identified linking. Masked value. Can be linked to masked value in elements with the same combined ID values.			P	Yes
37	Derived by DHCFP	Final Version Flag	5	varchar	Claim Line Final Version Flag - Derived by DHCFP in Versioning Process	Process sets to Highest Version any claim that is not a void or back out, not voided, not replaced, not a duplicate and where the Claim Status is not 04 (Denied) or 22 (Reversal). Claim Line Type may be Original, Replacement, or Amendment. ("True" or "False" indicate whether the claim line is a Final Version)			P	No
38	Derived by DHCFP	Unique Record ID: Public file	10	int	Unique Record ID - Derived by DHCFP	Unique Record ID for Dental Claim: Restricted File value matches Public File value for the same Claim Line.			P	No

Dental Claims - Restricted Use Data Elements										
Order	**Element**	**Data Element Name**	**Max Length**	**Data Type Guide**	**Description**	**Release Notes**	**Edit Level**	**APCD Threshold**	**Public / Restricted**	**Masked**
1	DC001	Payer	256	varbinary	Carrier Specific Submitter Code as defined by APCD. This must match the Submitter Code reported in HD002	A Division-assigned identifier for any APCD Data Submitter; Insurance, Benefit Manager/Administrator, TPA, Vendor	A0	100%	R	Yes
2	DC002	National Plan ID	256	varbinary	CMS National Plan Identification Number (PlanID)	Unique identifier as outlined by Centers for Medicare and Medicaid Services (CMS) for Plans.	Z	0%	R	Yes
3	DC003	Dental Insurance Type Code/Product	256	varbinary	Dental Product/Type Identifier (Lookup Table)	A code that defines the type of insurance applied to the claim line. This value can be derived from the claim as submitted by the provider or reassigned by the carrier or its designee.	C	98%	R	Yes

Dental Claims - Restricted Use Data Elements										
Order	**Element**	**Data Element Name**	**Max Length**	**Data Type Guide**	**Description**	**Release Notes**	**Edit Level**	**APCD Threshold**	**Public / Restricted**	**Masked**
4	DC004	Payer Claim Control Number	35	varchar	Payer Claim Control Identification	Unique identifier within the payer's system that applies to the entire claim.	A0	100%	R	Yes
5	DC006	Insured Group or Policy Number	256	varbinary	Carriers group or policy number	The carrier assigned group / policy number for this claim line. This information is often filed as reported by the provider.	C	98%	R	Yes
6	DC011	Individual Relationship Code	2	varchar	Member/Patient to Subscriber Relationship Code (Lookup Table)	Numeric indicator to report the Patient's relationship to the Subscriber. This value can be derived from the claim as submitted by the provider or reassigned by the carrier or its designee.	B	98%	R	No
7	DC013/ Month	Member Birth Month	10	int	Member/Patient's date of birth - Month only	Month of the Birth date of the Patient.	B		R	No
8	DC014	Member City Name	128	varchar	City name of the Member/Patient	City of the Patient.	B	99%	R	**No**
9	DC016/ First3	Member ZIP Code - First 3 Digits	3	varchar	First 3 Digits of 5 or 9 digit Zip Code as defined by the United States Postal Service.	Zip Code of Patient reported as first 3 digits.	B		R	No
10	DC017	Date Service Approved (AP Date)	23	datetime	The date the claim or service was approved for payment.	The date the service was approved for payment by the carrier or its designee. (YYYY-MM-DD 00:00:00.000)	C	98%	R	No
11	DC018	Service Provider Number	256	varbinary	Service Provider Identification Number	Link to PV002 on Provider File to obtain detailed attributes of the Service Provider.	A1	100%	R	Yes
12	DC019	Service Provider Tax ID Number	256	varbinary	Service Provider's Tax ID number	Tax ID of the Service Provider.	C	99%	R	Yes

Dental Claims - Restricted Use Data Elements										
Order	**Element**	**Data Element Name**	**Max Length**	**Data Type Guide**	**Description**	**Release Notes**	**Edit Level**	**APCD Threshold**	**Public / Restricted**	**Masked**
13	DC025	Delegated Benefit Administrator Organization ID	256	varbinary	DHCFP assigned Org ID for Benefit Administrator	Linking ID used by carriers to identify their Benefit Administrators / Managers, Vendors, etc. This value is a Division assigned identifier.	C	0%	R	Yes
14	DC035	Date of Service - From	23	datetime	Date of Service	First date of service for this claim line. (YYYY-MM-DD 00:00:00.000)	A0	99%	R	No
15	DC036	Date of Service - Thru	23	datetime	Last date of service for this service line.	Last date of service for this claim line. (YYYY-MM-DD 00:00:00.000)	B	0%	R	No
16	DC042	Product ID Number	256	varbinary	Product Identification Number	Link to PR001 on the Product File to obtain detailed attributes of the Product to which this claim line's member eligibility is associated.	A0	100%	R	Yes
17	DC044	Billing Provider Tax ID Number	256	varbinary	The Billing Provider's Federal Tax Identification Number (FTIN)	Tax ID of the Billing Provider.	C	90%	R	Yes
18	DC046	Allowed Amount	19	money	Allowed Amount	The maximum amount contractually allowed and payable for this claim line as defined by the carrier or its designee.	A2	99%	R	No
19	DC056	CarrierSpecificUniqueMemberID	256	varbinary	Member/Patient Carrier Unique Identification	Unique, internal identification assigned by the carrier or its designee to the Member. This can be used to link Claim Lines to member eligibility segments.	A0	100%	R	Yes
20	DC057	CarrierSpecificUniqueSubscriberID	256	varbinary	Subscriber Carrier Unique Identification	Unique, internal identification assigned by the carrier or its designee to the Subscriber. This can be used to link Claim Lines to eligibility segments.	A0	100%	R	Yes

Dental Claims - Restricted Use Data Elements										
Order	**Element**	**Data Element Name**	**Max Length**	**Data Type Guide**	**Description**	**Release Notes**	**Edit Level**	**APCD Threshold**	**Public / Restricted**	**Masked**
21	Derived by DHCFP	Unique Record ID: Restricted file	10	int	Unique Record ID - Derived by DHCFP	Unique Record ID for Dental Claim: Restricted File value matches Public File value for the same Claim Line.			R	No

Dental Claims - Unavailable Data Elements							
Order	**Element**	**Data Element Name**	**Description**	**Release Notes**	**Edit Level**	**APCD Threshold**	**Public / Restricted**
1	DC007	Subscriber SSN	Subscriber's Social Security Number	Tax ID of the Subscriber.	B	70%	not released
2	DC008	Plan Specific Contract Number	Plan Specific Contract Number	Plan-assigned contract/certificate number for the Subscriber and all of the corresponding dependents. This identifier must not disclose individuals.	C	70%	not released
3	DC009	Member Suffix or Sequence Number	Member/Patient's Contract Sequence Number	A unique identifier that is assigned to each beneficiary under a contract.	B	98%	not released
4	DC010	Member Identification Code	Member/Patient's Social Security Number	Tax ID of the Patient.	B	70%	not released
5	DC013	Member Date of Birth	Member/Patient's date of birth	Birth date of the Patient.	B	99%	not released
6	DC016	Member ZIP Code	5 or 9 digit Zip Code as defined by the United States Postal Service. (External Code Source 3)	5 or 9 digit Zip Code of the Patient.	B	99%	not released
7	DC043	Member Street Address	Street address of the Member/Patient	Street address of the Patient.	B	90%	not released

Dental Claims - Unavailable Data Elements							
Order	**Element**	**Data Element Name**	**Description**	**Release Notes**	**Edit Level**	**APCD Threshold**	**Public / Restricted**
8	DC050	Subscriber Last Name	Last name of Subscriber	Last name (or entity name) of the Subscriber.	B	100%	not released
9	DC051	Subscriber First Name	First name should exclude all punctuation, including hyphens and apostrophes, and be reported in upper case. Name should be contracted where punctuation is removed, do not report spaces. Example: Anne-Marie becomes ANNEMARIE.	First name of Subscriber, when appropriate	B	100%	not released
10	DC052	Subscriber Middle Initial	Middle initial of Subscriber	Middle initial of the Subscriber.	C	2%	not released
11	DC053	Member Last Name	Last name of Member/Patient	Last name of the Patient.	B	100%	not released
12	DC054	Member First Name	First name of Member/Patient	First name of the Patient.	B	100%	not released
13	DC055	Member Middle Initial	Middle initial of the Member/Patient	Middle initial of the Patient.	C	2%	not released
14	DC058	Member Address 2	Secondary Street Address of the Member/Patient	Street address 2 of the Patient.	B	2%	not released
15	DC060	Former Claim Number	Previous Claim Number	The Payer Claim Control Number previously assigned to this claim line in a prior reporting period.	B	0%	not released
16	Not collected by DHCFP	Service Provider Suffix	Provider name Suffix	The generational title of the provider. Not available for release.			not released

APCD Lookup Tables for Dental Claims, by Element										
Order	**Element**	**Data Element Name**	**Max Length**	**Data Type Guide**	**Description**	**Release Notes**	**Edit Level**	**APCD Threshold**	**Public / Restricted**	**Masked**
3	DC003	Dental Insurance Type Code/Product	256	varbinary	Dental Product/Type Identifier (Lookup Table)	A code that defines the type of insurance applied to the claim line. This value can be derived from the claim as submitted by the provider or reassigned by the carrier or its designee.	C	98%	R	Yes
					Claim Insurance Type Code	***Claim Insurance Type***				
					09	Self-pay				
					10	Central Certification				
					11	Other Non-Federal Programs				
					12	Preferred Provider Organization (PPO)				
					13	Point of Service (POS)				
					14	Exclusive Provider Organization (EPO)				
					15	Indemnity Insurance				
					16	Health Maintenance Organization (HMO) Medicare Risk				
					17	Dental Maintenance Organization (DMO)				
					AM	Automobile Medical				
					BL	Blue Cross / Blue Shield				
					CC	Commonwealth Care				
					CE	Commonwealth Choice				
					CH	Champus				
					CI	Commercial Insurance Co.				
					DS	Disability				
					HM	Health Maintenance Organization				
					LI	Liability				

APCD Lookup Tables for Dental Claims, by Element										
Ord-er	**Element**	**Data Element Name**	**Max Length**	**Data Type Guide**	**Description**	**Release Notes**	**Edit Level**	**APCD Thres-hold**	**Public / Restrict -ed**	**Masked**
					LM	Liability Medical				
					MA	Medicare Part A				
					MB	Medicare Part B				
					MC	Medicaid				
					OF	Other Federal Program				
					TV	Title V				
					VA	Veterans Administration Plan				
					WC	Workers' Compensation				
6	DC011	Individual Relationship Code	2	varchar	Member/Patient to Subscriber Relationship Code (Lookup Table)	Numeric indicator to report the Patient's relationship to the Subscriber. This value can be derived from the claim as submitted by the provider or reassigned by the carrier or its designee.	B	98%	R	No
					Individual Relationship Code	***Individual Relationship***				
					1	Spouse				
					4	Grandfather or Grandmother				
					5	Grandson or Granddaughter				
					7	Nephew or Niece				
					10	Foster Child				
					15	Ward				
					17	Stepson or Stepdaughter				
					19	Child				
					20	Self/Employee				
					21	Unknown				
					22	Handicapped Dependent				
					23	Sponsored Dependent				

APCD Lookup Tables for Dental Claims, by Element										
Ord-er	**Element**	**Data Element Name**	**Max Length**	**Data Type Guide**	**Description**	**Release Notes**	**Edit Level**	**APCD Thres-hold**	**Public / Restrict -ed**	**Masked**
					24	Dependent of a Minor Dependent				
					29	Significant Other				
					32	Mother				
					33	Father				
					36	Emancipated Minor				
					39	Organ Donor				
					40	Cadaver Donor				
					41	Injured Plaintiff				
					43	Child Where Insured Has No Financial Responsibility				
					53	Life Partner				
					76	Dependent				
3	DC012	Member Gender	1	varchar	Member/Patient's Gender (Lookup Table)	A code that defines the Patient's gender. This can be derived from the claim as submitted by the provider or reassigned by the carrier or its designee.	B	100%	P	No
					Gender Code	***Gender***				
					F	Female				
					M	Male				
					O	Other				
					U	Unknown				

APCD Lookup Tables for Dental Claims, by Element										
Order	**Element**	**Data Element Name**	**Max Length**	**Data Type Guide**	**Description**	**Release Notes**	**Edit Level**	**APCD Threshold**	**Public / Restricted**	**Masked**
7	DC021	Service Provider Entity Type Qualifier	1	varchar	Service Provider Entity Identifier Code (Lookup Table)	Numeric indicator to define the Service Provider as a person or non-person. This value drives various 'person' -type requirements; First Name, Date of Birth, Gender, etc.	A0	98%	P	No
					Service Provider Entity Type Qualifier Code	***Service Provider Entity Type Qualifier***				
					1	Person				
					2	Non-person entity				
16	DC031	Claim Status	2	varchar	Claim Line Status (Lookup Table)	Numeric indicator that reports if the claim line was paid by the carrier or its designee, and the COB order of the payment.	A0	90%	P	No
					Claim Status Code	***Claim Status***				
					01	Processed as primary				
					02	Processed as secondary				
					03	Processed as tertiary				
					04	Denied				
					19	Processed as primary, forwarded to additional payer(s)				
					20	Processed as secondary, forwarded to additional payer(s)				
					21	Processed as tertiary, forwarded to additional payer(s)				
					22	Reversal of previous payment				

APCD Lookup Tables for Dental Claims, by Element										
Ord-er	**Element**	**Data Element Name**	**Max Length**	**Data Type Guide**	**Description**	**Release Notes**	**Edit Level**	**APCD Thres-hold**	**Public / Restrict -ed**	**Masked**
29	DC059	Claim Line Type	10	varchar	Claim Line Activity Type Code (Lookup Table)	A code that reports the final outcome of the claim line during the submission period of the carrier or its designee. Example: Original, Void, Replacement, Back Out, Amendment.	A0	80%	P	No
					Claim Line Type Code	***Claim Line Type***				
					O	Original				
					V	Void				
					R	Replacement				
					B	Back Out				
					A	Amendment				

APCD Dental Claims: External Code Sources

Refer to Appendix 2 in this document: External Code Sources

The APCD Pharmacy Claims File

Pharmacy Claims File - Public Use Data Elements										
Order	**Element**	**Data Element Name**	**Max Length**	**Data Type Guide**	**Description**	**Release Notes**	**Edit Level**	**APCD Threshold**	**Public / Restricted**	**Masked**
1	PC005	Line Counter	10	int	Incremental Line Counter	The line number for this service on the claim. First line should start with 1, and each additional line incremented by 1.	A0	100%	P	No
2	PC005A	Version Number	10	int	Claim Service Version Number	Incrementing counter for a claim line that is reprocessed for any reason over the course of time. Highest value should indicate latest reprocessing of line by the carrier/submitter.	A0	100%	P	No
3	PC012	Member Gender	1	varchar	Member/Patient's Gender (Lookup Table)	A code that defines the Patient's gender. This can be derived from the claim as submitted by the provider or reassigned by the carrier or its designee.	B	100%	P	No
4	PC013/ Year	Member Birth Year	10	int	Member/Patient's date of birth - Year Only - Derived by DHCFP	Year of the Birth date of the Patient. Member Birth Year is reported as "999" when the Member is age 90 or older as of the Date Prescription Written.			P	No
5	PC015	Member State	2	varchar	State of the Member/Patient (External Code Source 2)	State of the Patient.	B	99%	P	No
6	PC020	Pharmacy Name	100	varchar	Name of Pharmacy	Name of the Pharmacy.	A2	90%	P	No
7	PC021	National Pharmacy ID Number	256	varbinary	National Provider Identification (NPI) of the Provider (External Code Source 4)	The National Provider ID (NPI) of the Pharmacy.	C	98%	P	Yes
8	PC022	Pharmacy Location City	30	varchar	City name of the Pharmacy	City of the Pharmacy.	B	85%	P	No
9	PC023	Pharmacy Location State	2	varchar	State of the Pharmacy	State of the Pharmacy.	B	90%	P	No
10	PC024	Pharmacy ZIP Code	5	varchar	5 or 9 digit Zip code of the Pharmacy (External Code Source 3)	Zip code of the Pharmacy.	B	90%	P	No

Pharmacy Claims File - Public Use Data Elements										
Order	**Element**	**Data Element Name**	**Max Length**	**Data Type Guide**	**Description**	**Release Notes**	**Edit Level**	**APCD Threshold**	**Public / Restricted**	**Masked**
11	PC024A	Pharmacy Country Code	30	varchar	Country Code of the Pharmacy Data requirement is a 3 digit code (External Code Source 1 (ISO 3166-1, alpha-3)).	Country of Pharmacy. Data requirement is a 3 digit code (External Code Source 1 (ISO 3166-1, alpha-3)).	B	90%	P	No
12	PC025	Claim Status	2	varchar	Claim Line Status (Lookup Table)	Numeric indicator that reports if the claim line was paid by the carrier or its designee, and the COB order of the payment.	A0	65%	P	No
13	PC026	Drug Code	11	varchar	National Drug Code (NDC)	A standard NDC Code as defined by the FDA in 5-4-2 format without hyphenation.	A0	90%	P	No
14	PC027	Drug Name	80	varchar	Name of the drug as supplied (External Code Source 12)	Name of the pharmaceutical supplied.	C	95%	P	No
15	PC028	New Prescription or Refill	3	varchar	Prescription Status Indicator	New Prescriptions identified with 00; Enumeration identifies current refill count.	A0	99%	P	No
16	PC029	Generic Drug Indicator	1	varchar	Generic Drug Indicator (Lookup Table)	Numeric indicator that reports if the pharmaceutical delivered was a generic product.	B	100%	P	No
17	PC030	Dispense as Written Code	1	varchar	Prescription Dispensing Activity Code (Lookup Table)	Numeric indicator that reports the dispensing activity of the pharmacy.	C	98%	P	No
18	PC031	Compound Drug Indicator	1	varchar	Compound Drug Indicator (Lookup Table)	Numeric indicator that reports if the pharmaceutical delivered is the result of combining two or more drugs.	C	98%	P	No
19	PC033	Quantity Dispensed	10	int	Claim line units dispensed	The number of metric units of medication dispensed.	A1	99%	P	No
20	PC034	Days Supply	10	int	Prescription Supply Days	Estimated number of days the prescription will last.	A2	99%	P	No
21	PC035	Charge Amount	19	money	Amount of provider charges for the claim line	Amount provider charged for the claim line service.	A0	99%	P	No
22	PC036	Paid Amount	19	money	Amount paid by the carrier for the claim line	The amount paid to the provider for this claim line.	A0	99%	P	No

Pharmacy Claims File - Public Use Data Elements										
Order	**Element**	**Data Element Name**	**Max Length**	**Data Type Guide**	**Description**	**Release Notes**	**Edit Level**	**APCD Threshold**	**Public / Restricted**	**Masked**
23	PC037	Ingredient Cost/List Price	19	money	Amount defined as the List Price or Ingredient Cost	The amount that the pharmacy has on file as the List Price.	A1	99%	P	No
24	PC038	Postage Amount Claimed	19	money	Amount of postage claimed on the claim line	The amount that a provider has reported as postage for reimbursement.	C	99%	P	No
25	PC039	Dispensing Fee	19	money	Amount of dispensing fee for the claim line	The amount that a provider has reported as a dispensing fee for reimbursement.	A1	99%	P	No
26	PC040	Copay Amount	19	money	Amount of Copay member/patient is responsible to pay	The copay amount applied to a claim line or full claim as calculated by the carrier or its designee.	A1	99%	P	No
27	PC041	Coinsurance Amount	19	money	Amount of coinsurance member/patient is responsible to pay	The coinsurance amount applied to a claim line or full claim as calculated by the carrier or its designee.	A1	99%	P	No
28	PC042	Deductible Amount	19	money	Amount of deductible member/patient is responsible to pay on the claim line	The deductible amount applied to a claim line or full claim as calculated by the carrier or its designee.	A1	99%	P	No
29	PC044	Prescribing Physician First Name	25	varchar	First name of Prescribing Physician	First name of the Prescribing Physician. Can be reported as NULL if DEA Number is present.	B	50%	P	No
30	PC045	Prescribing Physician Middle Name	25	varchar	Middle initial of Prescribing Physician	Middle name of the Prescribing Physician. Can be reported as NULL if DEA Number is present.	C	2%	P	No
31	PC046	Prescribing Physician Last Name	60	varchar	Last name of Prescribing Physician	Last Name of the Prescribing Physician. Can be reported as NULL if DEA Number is present.	B	50%	P	No
32	PC048	Prescribing Physician NPI	256	varbinary	National Provider Identification (NPI) of the Prescribing Physician (External Code Source 4)	The National Provider ID (NPI) of the Prescribing Provider.	C	80%	P	Yes

Pharmacy Claims File - Public Use Data Elements										
Order	**Element**	**Data Element Name**	**Max Length**	**Data Type Guide**	**Description**	**Release Notes**	**Edit Level**	**APCD Threshold**	**Public / Restricted**	**Masked**
33	PC049	Prescribing Physician Plan Number	256	varbinary	Prescribing Physicians Carrier Assigned Plan Number	Unique identifier assigned to the Prescribing Physician by the carrier or its designee. When the prescriber is not contracted with the carrier, this field will be null or reported as HCF-99907.	C	10%	P	Yes
34	PC050	Prescribing Physician License Number	256	varbinary	Prescribing Physician License Number	State license number of the Prescribing Physician identified in PV002.	B	10%	P	Yes
35	PC053	Prescribing Physician City	30	varchar	City name of the Prescribing Physician	City of the Prescribing Physician.	C	10%	P	No
36	PC054	Prescribing Physician State	2	varchar	State of the Physician (External Code Source 2)	State of the Prescribing Physician.	C	10%	P	No
37	PC055	Prescribing Physician Zip	5	varchar	Zip code of the Prescribing Physician (External Code Source 3)	Zip code of the Prescribing Physician.	C	10%	P	No
38	PC057	Mail Order pharmacy	1	varchar	Mail Order Pharmacy indicator (Lookup Table)	Numeric indicator that reports if this claim line was fulfilled by a mail order pharmacy.	B	100%	P	No
39	PC060	Single/Multiple Source Indicator	1	varchar	Drug Source Indicator (Lookup Table)	Numeric indicator that reports how the pharmaceutical was sourced.	B	90%	P	No
40	PC063	Paid Date	23	datetime	Paid date of the claim line	The date that appears on the check and/or remit and/or explanation of benefits and corresponds to any and all types of payment for this claim line. (YYYY-MM-DD 00:00:00.000)	A0	99%	P	No
41	PC066	Other Insurance Paid Amount	19	money	Amount paid by a Primary Carrier	The amount that another carrier paid for this claim line.	A2	90%	P	No
42	PC069	Member Self Pay Amount	19	money	Amount member/patient paid out of pocket on the claim line	The amount that the Patient has paid towards the claim line prior to submission to the carrier or its designee.	B	20%	P	No
43	PC070	Rebate Indicator	1	varchar	Drug Rebate Eligibility Indicator (Lookup Table)	Numeric indicator that reports if the claim line is eligible for financial rebate.	B	85%	P	No

Pharmacy Claims File - Public Use Data Elements										
Order	**Element**	**Data Element Name**	**Max Length**	**Data Type Guide**	**Description**	**Release Notes**	**Edit Level**	**APCD Threshold**	**Public / Restricted**	**Masked**
44	PC071	State Sales Tax	19	money	Amount of applicable sales tax on the claim line	Sales tax amount applied to the claim line.	B	80%	P	No
45	PC073	Formulary Code	1	varchar	Formulary inclusion identifier (Lookup Table)	Numeric indicator that reports if the pharmaceutical delivered is on the carrier's, or its designee's, list of covered drugs for the contract.	A0	90%	P	No
46	PC074	Route of Administration	2	varchar	Pharmaceutical Route of Administration Indicator (Lookup Table)	Numeric indicator that reports how the pharmaceutical is to be taken by the Patient.	B	80%	P	No
47	PC075	Drug Unit of Measure	3	varchar	Units of Measure (Lookup Table)	A code that reports the unit of measure for the pharmaceutical delivered.	A1	80%	P	No
48	PC110	Claim Line Type	10	varchar	Claim Line Activity Type Code (Lookup Table)	A code that reports the final outcome of the claim line during the submission period of the carrier or its designee. Example: Original, Void, Replacement, Back Out, Amendment	A0	90%	P	No
49	PC899	Record Type	2	varchar	File Type Identifier	The APCD filing-type identifier that defines the data contained within the file.	A0	100%	P	No
50	PC001 / PC018	Payer / Pharmacy Number	256	varbinary	Submitter Org ID as defined by DHCFP/ Pharmacy NCPDP or NABP ID	Combined Payer/ Pharmacy Number for de-identified linking. Masked value. Can be linked to masked value in elements with the same combined ID values.			P	Yes
51	PC001 / PC043	Payer / Prescribing ProviderID	256	varbinary	Submitter Org ID as defined by DHCFP/ Prescribing Provider Number	Combined Payer/ Provider ID for de-identified linking. Masked value. Can be linked to masked value in elements with the same combined ID values.			P	Yes
52	PC001 / PC056	Payer / Product ID Number	256	varbinary	Submitter Org ID as defined by DHCFP/ Product Identification Number	Combined Payer/ Product ID for de-identified linking. Masked value. Can be linked to masked value in elements with the same combined ID values.			P	Yes

Pharmacy Claims File - Public Use Data Elements										
Order	**Element**	**Data Element Name**	**Max Length**	**Data Type Guide**	**Description**	**Release Notes**	**Edit Level**	**APCD Threshold**	**Public / Restricted**	**Masked**
53	PC001 / PC059	Payer / Recipient PCP ID	256	varbinary	Submitter Org ID as defined by DHCFP/ Member/Patient's Carrier-defined PCP ID	Combined Payer/ PCP ID for de-identified linking. Masked value. Can be linked to masked value in elements with the same combined ID values.			P	Yes
54	PC001 / PC072	Payer / Delegated Benefit Administrator Organization ID	256	varbinary	Submitter Org ID as defined by DHCFP/ DHCFP assigned Org ID for Benefit Administrator	Combined Payer/ DBA ID for de-identified linking. Masked value. Can be linked to masked value in elements with the same combined ID values.			P	Yes
55	PC001 / PC107	Payer / CarrierSpecificUniqueMemberID	256	varbinary	Submitter Org ID as defined by DHCFP/ Carrier-assigned Member/Patient Unique ID	Combined Payer/ Member ID for de-identified linking. Masked value. Can be linked to masked value in elements with the same combined ID values.			P	Yes
56	PC001 / PC108	Payer / CarrierSpecificUniqueSubscriberID	256	varbinary	Submitter Org ID as defined by DHCFP/ Subscriber Carrier Unique Identification	Combined Payer/ Subscriber ID for de-identified linking. Masked value. Can be linked to masked value in elements with the same combined ID values.			P	Yes
57	Derived by DHCFP	Final Version Flag	5	varchar	Claim Line Final Version Flag - Derived by DHCFP in Versioning Process	Process sets to Highest Version any claim that is not a void or back out, not voided, not replaced, not a duplicate and where the Claim Status is not 04 (Denied) or 22 (Reversal). Claim Line Type may be Original, Replacement, or Amendment. ("True" or "False" indicate whether the claim line is a Final Version)			P	No
58	Derived by DHCFP	Unique Record ID: Public File	10	int	Unique Record ID - Derived by DHCFP	Unique Record ID for Pharmacy Claim: Restricted File value matches Public File value for the same Claim Line.			P	No

Pharmacy Claims File - Restricted Use Data Elements										
Order	**Element**	**Data Element Name**	**Max Length**	**Data Type Guide**	**Description**	**Release Notes**	**Edit Level**	**APCD Threshold**	**Public / Restricted**	**Masked**
1	PC001	Payer	256	varbinary	Carrier Specific Submitter Code as defined by APCD. This must match the Submitter Code reported in HD002	A Division assigned identifier for any APCD Data Submitter; Insurance, Benefit Manager/Administrator, TPA, Vendor	A0	100%	R	Yes
2	PC002	Plan ID	256	varbinary	CMS National Plan Identification Number (PlanID)	Unique identifier as outlined by Centers for Medicare and Medicaid Services (CMS) for Plans.	Z	0%	R	Yes
3	PC003	Insurance Type Code/Product	256	varbinary	Type / Product Identification Code (Lookup Table)	A code that defines the type of insurance applied to the claim line. This value can be derived from the claim as submitted by the provider or reassigned by the carrier or its designee.	C	95%	R	Yes
4	PC004	Payer Claim Control Number	256	varbinary	Payer Claim Control Identification	Unique identifier within the payer's system that applies to the entire claim.	A0	100%	R	Yes
5	PC006	Insured Group or Policy Number	256	varbinary	Carriers group or policy number	The carrier assigned group / policy number for this claim line. This information is often filed as reported by the provider.	C	98%	R	Yes
6	PC011	Individual Relationship Code	2	varchar	Member/Patient to Subscriber Relationship Code (Lookup Table)	Numeric indicator to define the Patient's relationship to the Subscriber. This value can be derived from the claim as submitted by the provider or reassigned by the carrier or its designee.	B	85%	R	No
7	PC013/ Month	Member Birth Month	10	int	Member/Patient's date of birth - Month Only	Month of the Birth date of the Patient.			R	No
8	PC014	Member City Name of Residence	128	varchar	City name of the Member/Patient	City of the Patient.	B	99%	R	No
9	PC016/ First3	First 3 of Member zip code	3	varchar	Zip Code of the Member/Patient - First 3 digits	First three digits of the Zip Code of the Member/Patient.			R	No

Pharmacy Claims File - Restricted Use Data Elements										
Order	**Element**	**Data Element Name**	**Max Length**	**Data Type Guide**	**Description**	**Release Notes**	**Edit Level**	**APCD Threshold**	**Public / Restricted**	**Masked**
10	PC017	Date Service Approved (AP Date)	23	datetime	Date Service Approved	The date the service was approved for payment by the carrier or its designee. (YYYY-MM-DD 00:00:00.000)	C	99%	R	No
11	PC018	Pharmacy Number	256	varbinary	Pharmacy Number	Unique identifier assigned to a pharmacy by either the NAPD or the NCPDP	A0	98%	R	Yes
12	PC019	Pharmacy Tax ID Number	256	varbinary	Pharmacy Tax Identification Number	Tax ID of the Pharmacy.	C	20%	R	Yes
13	PC032	Date Prescription Filled	23	datetime	Prescription filled date	The date that the pharmacy filled AND dispensed prescription to the Patient. (YYYY-MM-DD 00:00:00.000)	A0	99%	R	No
14	PC032/ Month	Date Prescription Filled Month	10	int	Prescription filled date - Month only	The Month of the date that the pharmacy filled AND dispensed prescription to the Patient.			R	No
15	PC032/ Year	Date Prescription Filled Year	10	int	Prescription filled date - Year only	The Year of the date that the pharmacy filled AND dispensed prescription to the Patient.			R	No
16	PC043	Prescribing ProviderID	28	varchar	Prescribing Provider Number	Link to PV002 on the Provider File to obtain detailed attributes of the Prescribing Provider. (Refer to Linking section of the Release Document.)	A0	80%	R	Yes
17	PC047	Prescribing Physician DEA Number	256	varbinary	Prescribing Physicians DEA Number	The DEA number for prescribing physician.	B	80%	R	Yes
18	PC051	Prescribing Physician Street Address	50	varchar	Street address of the Prescribing Physician	Street address of the Prescribing Physician.	C	10%	R	No
19	PC052	Prescribing Physician Street Address 2	50	varchar	Secondary Street Address of the Prescribing Physician	Street address 2 of the Prescribing Physician.	C	2%	R	No
20	PC056	Product ID Number	256	varbinary	Product Identification Number	Link to PR001 on the Product File to obtain detailed attributes of the product that the eligibility for this claim line is associated to.	A0	100%	R	Yes

Pharmacy Claims File - Restricted Use Data Elements										
Order	**Element**	**Data Element Name**	**Max Length**	**Data Type Guide**	**Description**	**Release Notes**	**Edit Level**	**APCD Threshold**	**Public / Restricted**	**Masked**
21	PC058	Script number	20	varchar	Prescription Number	Unique identifier of the actual prescription written by the prescribing provider.	B	100%	R	No
22	PC059	Recipient PCP ID	256	varbinary	Member/Patient's PCP Provider ID	Link to PV002 on the Provider File to obtain detailed attributes of the Patient's Primary Care Provider.	B	98%	R	Yes
23	PC062	Billing Provider Tax ID Number	256	varbinary	The Billing Provider's Federal Tax Identification Number (FTIN)	Tax ID of the Billing Provider.	C	90%	R	Yes
24	PC064	Date Prescription Written	23	datetime	Date prescription was prescribed	The date the prescribing physician wrote or called-in the prescription. (YYYY-MM-DD 00:00:00.000)	B	80%	R	No
25	PC064/ Month	Date Prescription Written Month	10	int	Date prescription was prescribed - Month only	The Month of the date the prescribing physician wrote or called-in the prescription.			R	No
26	PC064/ Year	Date Prescription Written Year	10	int	Date prescription was prescribed - Year only	The Year of the date the prescribing physician wrote or called-in the prescription.			R	No
27	PC068	Allowed amount	19	money	Allowed Amount	The maximum amount contractually allowed and payable for this claim line as defined by the carrier or its designee.	A2	99%	R	No
28	PC072	Delegated Benefit Administrator Organization ID	256	varbinary	DHCFP assigned Org ID for Benefit Administrator	Linking ID used by carriers to identify their Benefit Administrators / Managers, Vendors, etc. This value is a Division assigned identifier.	C	0%	R	Yes
29	PC107	CarrierSpecificUniqueMemberID	256	varbinary	Member/Patient Carrier Unique Identification	Unique, internal identification assigned by the carrier or its designee to the Member. This can be used to link Claim Lines to eligibility segments.	A0	100%	R	Yes
30	PC108	CarrierSpecificUniqueSubscriberID	256	varbinary	Subscriber Carrier Unique Identification	Unique, internal identification assigned by the carrier or its designee to the Subscriber. This can be used to link Claim Lines to eligibility segments.	A0	100%	R	Yes

Pharmacy Claims File - Restricted Use Data Elements										
Order	**Element**	**Data Element Name**	**Max Length**	**Data Type Guide**	**Description**	**Release Notes**	**Edit Level**	**APCD Threshold**	**Public / Restricted**	**Masked**
31	Derived by DHCFP	Unique Record ID: Restricted File	10	int	Unique Record ID - Derived by DHCFP	Unique Record ID for Pharmacy Claim: Restricted File value matches Public File value for the same Claim Line.			R	No

Pharmacy Claims File - Unavailable Data Elements							
Order	**Element**	**Data Element Name**	**Description**	**Release Notes**	**Edit Level**	**APCD Threshold**	**Public / Restricted**
1	PC007	Subscriber SSN	Subscriber's Social Security Number	Tax ID of the Subscriber.	B	85%	not released
2	PC008	Plan Specific Contract Number	Plan Specific Contract Number	Plan assigned contract/certificate number for the Subscriber and all of the corresponding dependents. This identifier must not disclose individuals.	C	98%	not released
3	PC009	Member Suffix or Sequence Number	Member/Patient's Contract Sequence Number	A unique identifier that is assigned to each beneficiary under a contract.	B	98%	not released
4	PC010	Member SSN	Member/Patient's Social Security Number	Tax ID of the Patient.	B	98%	not released
5	PC013	Member Date of Birth	Member/Patient's date of birth	Birth date of the Patient.	B	99%	not released
6	PC016	Member ZIP Code	Zip Code of the Member/Patient (External Code Source 3)	5 or 9 digit Zip Code of the Patient.	B	99%	not released
7	PC061	Member Street Address	Street address of the Member/Patient	Street address of the Patient.	B	90%	not released
8	PC065	Coordination of Benefits/TPL Liability Amount - GIC Only	Amount due from a Secondary Carrier when known	The amount that another carrier/insurer is liable for as determined by the carrier or its designee after their adjudication.	B	0%	not released

Pharmacy Claims File - Unavailable Data Elements							
Order	**Element**	**Data Element Name**	**Description**	**Release Notes**	**Edit Level**	**APCD Threshold**	**Public / Restricted**
9	PC067	Medicare Paid Amount - GIC Only	Amount Medicare paid on claim	The amount that Medicare paid towards this claim line prior to carrier adjudication.	A1	0%	not released
10	PC101	Subscriber Last Name	Last name of Subscriber	Last name (or entity name) of the Subscriber.	B	98%	not released
11	PC102	Subscriber First Name	First name of the Subscriber	First name of Subscriber, when appropriate.	A2	98%	not released
12	PC103	Subscriber Middle Initial	Middle initial of Subscriber	Middle initial of the Subscriber.	C	2%	not released
13	PC104	Member Last Name	Last name of Member/Patient	Last name of the Patient.	B	98%	not released
14	PC105	Member First Name	First name of Member/Patient	First name of the Patient.	A1	98%	not released
15	PC106	Member Middle Initial	Middle initial of the Member/Patient	Middle initial of the Patient.	C	2%	not released
16	PC109	Member Street Address 2	Secondary Street Address of the Member/Patient	Street address 2 of the Patient.	B	0%	not released
17	PC111	Former Claim Number	Previous Claim Number	The Payer Claim Control Number previously assigned to this claim line in a prior reporting period.	B	0%	not released

APCD Pharmacy Claims File Lookup Tables, by Element										
Order	**Element**	**Data Element Name**	**Max Length**	**Data Type Guide**	**Description**	**Release Notes**	**Edit Level**	**APCD Threshold**	**Public / Restricted**	**Masked**
3	PC003	Insurance Type Code/Product	256	varbinary	Type / Product Identification Code (Lookup Table)	A code that defines the type of insurance applied to the claim line. This value can be derived from the claim as submitted by the provider or reassigned by the carrier or its designee.	C	95%	R	Yes
					Claim Insurance Type Code	***Claim Insurance Type***				
					09	Self-pay				
					10	Central Certification				
					11	Other Non-Federal Programs				
					12	Preferred Provider Organization (PPO)				
					13	Point of Service (POS)				
					14	Exclusive Provider Organization (EPO)				
					15	Indemnity Insurance				
					16	Health Maintenance Organization (HMO) Medicare Risk				
					17	Dental Maintenance Organization (DMO)				
					AM	Automobile Medical				
					BL	Blue Cross / Blue Shield				
					CC	Commonwealth Care				
					CE	Commonwealth Choice				
					CH	Champus				
					CI	Commercial Insurance Co.				
					DS	Disability				
					HM	Health Maintenance Organization				
					LI	Liability				

APCD Pharmacy Claims File Lookup Tables, by Element										
Ord-er	**Element**	**Data Element Name**	**Max Length**	**Data Type Guide**	**Description**	**Release Notes**	**Edit Level**	**APCD Thres-hold**	**Public / Restrict-ed**	**Mask-ed**
					LM	Liability Medical				
					MA	Medicare Part A				
					MB	Medicare Part B				
					MC	Medicaid				
					OF	Other Federal Program				
					TV	Title V				
					VA	Veterans Administration Plan				
					WC	Workers' Compensation				
6	PC011	Individual Relationship Code	2	varchar	Member/Patient to Subscriber Relationship Code (Lookup Table)	Numeric indicator to define the Patient's relationship to the Subscriber. This value can be derived from the claim as submitted by the provider or reassigned by the carrier or its designee.	B	85%	R	No
					Individual Relationship Code	***Individual Relationship***				
					1	Spouse				
					4	Grandfather or Grandmother				
					5	Grandson or Granddaughter				
					7	Nephew or Niece				
					10	Foster Child				
					15	Ward				
					17	Stepson or Stepdaughter				
					19	Child				
					20	Self/Employee				
					21	Unknown				
					22	Handicapped Dependent				
					23	Sponsored Dependent				

APCD Pharmacy Claims File Lookup Tables, by Element										
Ord-er	**Element**	**Data Element Name**	**Max Length**	**Data Type Guide**	**Description**	**Release Notes**	**Edit Level**	**APCD Thres-hold**	**Public / Restrict-ed**	**Mask-ed**
					24	Dependent of a Minor Dependent				
					29	Significant Other				
					32	Mother				
					33	Father				
					36	Emancipated Minor				
					39	Organ Donor				
					40	Cadaver Donor				
					41	Injured Plaintiff				
					43	Child Where Insured Has No Financial Responsibility				
					53	Life Partner				
					76	Dependent				
3	PC012	Member Gender	1	varchar	Member/Patient's Gender (Lookup Table)	A code that defines the Patient's gender. This can be derived from the claim as submitted by the provider or reassigned by the carrier or its designee.	B	100%	P	No
					Gender Code	***Gender***				
					F	Female				
					M	Male				
					O	Other				
					U	Unknown				
12	PC025	Claim Status	2	varchar	Claim Line Status (Lookup Table)	Numeric indicator that reports if the claim line was paid by the carrier or its designee, and the COB order of the payment.	A0	65%	P	No
					Claim Status Code	***Claim Status***				
					01	Processed as primary				

APCD Pharmacy Claims File Lookup Tables, by Element										
Ord-er	**Element**	**Data Element Name**	**Max Length**	**Data Type Guide**	**Description**	**Release Notes**	**Edit Level**	**APCD Thres-hold**	**Public / Restrict-ed**	**Mask-ed**
					02	Processed as secondary				
					03	Processed as tertiary				
					04	Denied				
					19	Processed as primary, forwarded to additional payer(s)				
					20	Processed as secondary, forwarded to additional payer(s)				
					21	Processed as tertiary, forwarded to additional payer(s)				
					22	Reversal of previous payment				
16	PC029	Generic Drug Indicator	1	varchar	Generic Drug Indicator (Lookup Table)	Numeric indicator that reports if the pharmaceutical delivered was a generic product.	B	100%	P	No
					Value	***Description***				
					1	Yes				
					2	No				
					3	Unknown				
					4	Other				
					5	Not Applicable				
17	PC030	Dispense as Written Code	1	varchar	Prescription Dispensing Activity Code (Lookup Table)	Numeric indicator that reports the dispensing activity of the pharmacy.	C	98%	P	No
					Dispense As Written Code	***Dispense As Written***				
					0	Not dispensed as written				
					1	Physician dispense as written				
					2	Member dispense as written				
					3	Pharmacy dispense as written				
					4	No generic available				

APCD Pharmacy Claims File Lookup Tables, by Element										
Ord-er	**Element**	**Data Element Name**	**Max Length**	**Data Type Guide**	**Description**	**Release Notes**	**Edit Level**	**APCD Thres-hold**	**Public / Restrict-ed**	**Mask-ed**
					5	Brand dispensed as generic				
					6	Override				
					7	Substitution not allowed, brand drug mandated by law				
					8	Substitution allowed, generic drug not available in marketplace				
					9	Other				
18	PC031	Compound Drug Indicator	1	varchar	Compound Drug Indicator (Lookup Table)	Numeric indicator that reports if the pharmaceutical delivered is the result of combining two or more drugs.	C	98%	P	No
					Value	***Description***				
					1	Yes				
					2	No				
					3	Unknown				
					4	Other				
					5	Not Applicable				
38	PC057	Mail Order pharmacy	1	varchar	Mail Order Pharmacy indicator (Lookup Table)	Numeric indicator that reports if this claim line was fulfilled by a mail order pharmacy.	B	100%	P	No
					Value	***Description***				
					1	Yes				
					2	No				
					3	Unknown				
					4	Other				
					5	Not Applicable				

APCD Pharmacy Claims File Lookup Tables, by Element										
Order	**Element**	**Data Element Name**	**Max Length**	**Data Type Guide**	**Description**	**Release Notes**	**Edit Level**	**APCD Threshold**	**Public / Restricted**	**Masked**
39	PC060	Single/Multiple Source Indicator	1	varchar	Drug Source Indicator (Lookup Table)	Numeric indicator that reports how the pharmaceutical was sourced.	B	90%	P	No
					Value	***Description***				
					1	Multi-source brand				
					2	Multi-source brand with generic equivalent				
					3	Single source brand				
					4	Single source brand with generic equivalent				
					5	Unknown				
43	PC070	Rebate Indicator	1	varchar	Drug Rebate Eligibility Indicator (Lookup Table)	Numeric indicator that reports if the claim line is eligible for financial rebate.	B	85%	P	No
					Value	***Description***				
					1	Yes				
					2	No				
					3	Unknown				
					4	Other				
					5	Not Applicable				
45	PC073	Formulary Code	1	varchar	Formulary inclusion identifier (Lookup Table)	Numeric indicator that reports if the pharmaceutical delivered is on the carrier's, or its designee's, list of covered drugs for the contract.	A0	90%	P	No
					Value	***Description***				
					1	Yes				
					2	No				
					3	Unknown				

APCD Pharmacy Claims File Lookup Tables, by Element										
Ord-er	**Element**	**Data Element Name**	**Max Length**	**Data Type Guide**	**Description**	**Release Notes**	**Edit Level**	**APCD Thres-hold**	**Public / Restrict-ed**	**Mask-ed**
					4	Other				
					5	Not Applicable				
46	PC074	Route of Administration	2	varchar	Pharmaceutical Route of Administration Indicator (Lookup Table)	Numeric indicator that reports how the pharmaceutical is to be taken by the Patient.	B	80%	P	No
					Route Of Administration Code	***Route Of Administration***				
					00	Not Specified				
					01	Buccal				
					02	Dental				
					03	Inhalation				
					04	Injection				
					05	Intraperitoneal				
					06	Irrigation				
					07	Mouth / Throat				
					08	Mucous Membrane				
					09	Nasal				
					10	Ophthalmic				
					11	Oral				
					12	Other / Misc				
					13	Otic				
					14	Perfusion				
					15	Rectal				
					16	Sublingual				
					17	Topical				
					18	Transdermal				

APCD Pharmacy Claims File Lookup Tables, by Element										
Order	**Element**	**Data Element Name**	**Max Length**	**Data Type Guide**	**Description**	**Release Notes**	**Edit Level**	**APCD Threshold**	**Public / Restricted**	**Masked**
					19	Translingual				
					20	Urethral				
					21	Vaginal				
					22	Enteral				
47	PC075	Drug Unit of Measure	3	varchar	Units of Measure (Lookup Table)	A code that reports the unit of measure for the pharmaceutical delivered.	A1	80%	P	No
					Measure Code	***Measure***				
					EA	Each				
					GM	Grams				
					ML	Milliliters				
48	PC110	Claim Line Type	10	varchar	Claim Line Activity Type Code (Lookup Table)	A code that reports the final outcome of the claim line during the submission period of the carrier or its designee. Example: Original, Void, Replacement, Back Out, Amendment	A0	90%	P	No
					Claim Line Type Code	***Claim Line Type***				
					O	Original				
					V	Void				
					R	Replacement				
					B	Back Out				
					A	Amendment				

Pharmacy Claims File: External Code Sources

Refer to Appendix 2 in this document: External Code Sources

The APCD Provider File

Provider File - Public Use Data Elements										
Order	**Element**	**Data Element Name**	**Max Length**	**Data Type Guide**	**Description**	**Release Notes**	**Edit Level**	**APCD Threshold**	**Public / Restricted**	**Masked**
1	PV006	License Id	256	varbinary	State practice license for the Provider in PV002	This is the unique State Licensing Boards' ID of the provider reported in this segment. This can be any of the applicable IDs; Registry in Medicine, Nursing, Dentistry, etc.	B	80%	P	Yes
2	PV008	Last Name	50	varchar	Last name of the Provider in PV002	Last name of the Provider when Provider ID code = 1 (Person).	A0	98%	P	No
3	PV009	First Name	50	varchar	First name of the Provider in PV002	First name of the Provider when Provider ID Code = 1 (Person).	A2	98%	P	No
4	PV010	Middle Initial	1	varchar	Middle initial of the Provider in PV002	Middle initial of the Provider when Provider ID Code = 1 (Person).	C	1%	P	No
5	PV011	Suffix	2	varchar	Suffix of the Provider in PV002	The generational title of the Provider when the Provider ID Code = 1 (Person).	Z	1%	P	No
6	PV012	Entity Name	100	varchar	Group / Facility name	Name of the Provider as an Entity. Providers as Persons are reported in Last, First and Middle Initial Name segments.	A1	98%	P	No
7	PV013	Entity Code	10	varchar	Provider facility code (Lookup Table)	Numeric indicator that reports the type of facility the carrier or its designee has on file for the provider. When the provider is an individual, 31 (Other) should be reported here.	A0	98%	P	No
8	PV014	Gender Code	1	varchar	Gender of Provider (Lookup Table)	A code that defines the Provider's gender when the Provider is identified as an individual in ProviderID Code (1 = Individual)	B	20%	P	No
9	PV018	City Name	128	varchar	City of the Provider	City of the Provider Practice Site.	A1	98%	P	No
10	PV019	State Code	2	varchar	State of the Provider (External Code Source 2)	State of the Provider Practice Site.	A0	98%	P	No

Provider File - Public Use Data Elements										
Order	**Element**	**Data Element Name**	**Max Length**	**Data Type Guide**	**Description**	**Release Notes**	**Edit Level**	**APCD Threshold**	**Public / Restricted**	**Masked**
11	PV020	Country Code	30	varchar	Country Code of the Provider (External Code Source 1 (ISO 3166-1, alpha-3))	Country of the Provider Practice Site. Data requirement is a 3 digit code	C	98%	P	No
12	PV021	Zip Code	5	varchar	Zip code of the Provider (External Code Source 3)	Zip Code of the Provider Practice Site.	A0	98%	P	No
13	PV022	Taxonomy	10	varchar	Primary Taxonomy Code of the Provider (External Code Source 13 - AND/OR - Carrier Defined Reference Table)	A standardized taxonomy code OR a carrier-defined specialty code of the Servicing Provider.	C	50%	P	No
14	PV023	Mailing Street Address1 Name	128	varchar	Street address of the Provider / Entity	Street address of the Provider - Mailing.	A0	98%	P	No
15	PV024	Mailing Street Address2 Name	128	varchar	Secondary Street address of the Provider / Entity	Street address 2 of the Provider - Mailing.	B	2%	P	No
16	PV025	Mailing City Name	128	varchar	City name of the Provider / Entity	City of the Provider - Mailing.	A0	98%	P	No
17	PV026	Mailing State Code	2	varchar	State name of the Provider / Entity (External Code Source 2)	State of the Provider - Mailing.	A0	98%	P	No
18	PV027	Mailing Country Code	30	varchar	Country Code of the Provider (External Code Source 1 (ISO 3166-1, alpha-3))	Country of the Provider - Mailing. Data requirement is a 3 digit code.	C	98%	P	No
19	PV028	Mailing Zip Code	5	varchar	Zip code of the Provider (External Code Source 3)	Zip Code of the Provider - Mailing.	A0	98%	P	No
20	PV029	Provider Type Code	10	varchar	Provider Type Code (Carrier Defined Reference Table)	The Provider Type code associated with the individual provider or facility as defined by the submitting carrier or its designee. This element distinguishes individuals from facilities, etc.	A1	98%	P	No
21	PV030	Primary Specialty Code	15	varchar	Specialty Code (External Code Source 13 - AND/OR - Carrier Defined Reference Table)	The primary standardized taxonomy code OR a carrier-defined specialty code of the Provider.	B	98%	P	No

Provider File - Public Use Data Elements										
Order	**Element**	**Data Element Name**	**Max Length**	**Data Type Guide**	**Description**	**Release Notes**	**Edit Level**	**APCD Threshold**	**Public / Restricted**	**Masked**
22	PV034	ProviderIDCode	5	varchar	Provider Identification Code (Lookup Table)	Numeric code that reports the type of entity associated with the Plan Provider ID	A0	100%	P	No
23	PV037	Begin Date	23	datetime	Provider Start Date	The Date the provider or facility becomes eligible/contracted to perform services for plan Members/insureds. Providers who do not render services should have this field blank. (YYYY-MM-DD 00:00:00.000)	A2	98%	P	No
24	PV038	End Date	23	datetime	Provider End Date	The Date the provider or facility is no longer eligible/contracted to perform services for plan Members/insureds. Providers who do not render services should have this field blank. (YYYY-MM-DD 00:00:00.000)	B	98%	P	No
25	PV039	National Provider ID	256	varbinary	National Provider Identification (NPI) of the National Provider (External Code Source 4)	The primary National Provider ID (NPI) of the Provider.	B	98%	P	Yes
26	PV040	National Provider2 ID	256	varbinary	National Provider Identification (NPI) of the Provider (External Code Source 4)	The secondary National Provider ID (NPI) of the Provider.	C	1%	P	Yes
27	PV042	Secondary Specialty2 Code	15	varchar	Specialty Code (External Code Source 13 - AND/OR - Carrier Defined Reference Table)	A secondary standardized taxonomy code OR a carrier-defined specialty code of the Provider.	B	1%	P	No
28	PV043	Secondary Specialty3 Code	15	varchar	Specialty Code (External Code Source 13 - AND/OR - Carrier Defined Reference Table)	A tertiary standardized taxonomy code OR a carrier-defined specialty code of the Provider.	B	0%	P	No
29	PV044	Secondary Specialty4 Code	15	varchar	Specialty Code (External Code Source 13 - AND/OR - Carrier Defined Reference Table)	A quaternary standardized taxonomy code OR a carrier-defined specialty code of the Provider.	B	0%	P	No

Provider File - Public Use Data Elements										
Order	**Element**	**Data Element Name**	**Max Length**	**Data Type Guide**	**Description**	**Release Notes**	**Edit Level**	**APCD Threshold**	**Public / Restricted**	**Masked**
30	PV045	P4PFlag	1	varchar	Pay-for-Performance (P4P) indicator (Lookup Table)	Numeric indicator that reports if the provider has a Pay-for-Performance agreement with the carrier, or its designee, for the time-period on this provider segment.	B	100%	P	No
31	PV046	NonClaimsFlag	1	varchar	Non-claims Financial Transaction Indicator (Lookup Table)	Numeric indicator that reports if the provider received non-claims based payments during the time-period of this provider segment.	B	100%	P	No
32	PV047	Uses Electronic Medical Records	1	varchar	Provider Uses EMR indicator (Lookup Table)	Numeric indicator that reports if the provider utilized electronic medical records during the time-period reported on this provider segment.	B	100%	P	No
33	PV048	EMR Vendor	40	varchar	Electronic Medical Record Vendor name	Name of the vendor the Provider uses for Electronic Medical Records processing.	Z	0%	P	No
34	PV049	Accepting New Patients	1	varchar	Indicates if provider or provider group is accepting new patients as it applies to this carrier's products/plans. (Lookup Table)	Numeric indicator that reports if the provider is accepting new Patients/cases during the time-period reported on this provider segment.	B	100%	P	No
35	PV050	Offers e-Visits	1	varchar	Indicates if the provider uses eVisit tools (web based software) for well visits. (Lookup Table)	Numeric indicator that reports if the provider offers e-Visits.	C	100%	P	No
36	PV052	Has multiple offices	1	varchar	Indicates if the provider has multiple office locations where it sees patients. (Lookup Table)	Flag indicating if the provider has more than one practice site	A0	100%	P	No
37	PV055	PCP Flag	1	varchar	Indicates if the provider is a PCP. For Facilities or entities where this is not applicable, value of N (No) is allowed. (Lookup Table)	Numeric indicator that reports if the provider (persons only) is a Primary Care Provider during the time-period of this provider segment.	A0	100%	P	No
38	PV057	Provider Telephone	10	varchar	Telephone number associated with the provider identified in PV002.	Telephone number of the individual reported in Last Name or the entity reported in Entity Name.	C	10%	P	No

Provider File - Public Use Data Elements										
Order	**Element**	**Data Element Name**	**Max Length**	**Data Type Guide**	**Description**	**Release Notes**	**Edit Level**	**APCD Threshold**	**Public / Restricted**	**Masked**
39	PV058	Delegated Provider Record Flag	1	varchar	Provider Record Source Indicator (Lookup Table)	Numeric indicator that reports if the provider record was sourced from a delegated provider system.	B	100%	P	No
40	PV060	Office Type	1	varchar	Office Type Code (Lookup Table)	Numeric indicator that reports the type of office the provider is associated with in this provider segment.	A0	95%	P	No
41	PV061	Prescribing Provider	1	varchar	Prescribing privilege indicator (Lookup Table)	Numeric indicator that reports if the provider has prescribing privileges during the time-period on this provider segment.	C	100%	P	No
42	PV062	Provider Affiliation Start Date	23	datetime	Provider Affiliation Start Date	Start Date of the Provider's affiliation to the entity reported in Provider Affiliation; a link to another PV002 on the Provider File to obtain detailed attributes of the affiliated entity. If no affiliation exists, carriers are to repeat the date reported in Begin Date. (YYYY-MM-DD 00:00:00.000)	A0	98%	P	No
43	PV063	Provider Affiliation End Date	23	datetime	Provider Affiliation End Date	End date of the Provider's affiliation to the entity reported in Provider Affiliation; a link to another PV002 on the Provider File to obtain detailed attributes of the affiliated entity. If no affiliation exists, carriers are to repeat the date reported in End Date. (YYYY-MM-DD 00:00:00.000)	B	98%	P	No
44	PV064	PPO Indicator	1	varchar	Indicates if the provider is a contracted provider (Lookup Table)	Numeric indicator that reports if the provider is a Preferred Provider Organization during the time-period reported on this provider segment.	A0	100%	P	No
45	PV899	Record Type	2	varchar	File Type Identifier	The APCD filing-type identifier that defines the data contained within the file.	A0	100%	P	No

Provider File - Public Use Data Elements										
Order	**Element**	**Data Element Name**	**Max Length**	**Data Type Guide**	**Description**	**Release Notes**	**Edit Level**	**APCD Threshold**	**Public / Restricted**	**Masked**
46	PV001/ PV002	Payer / Plan Provider ID	256	varbinary	Submitter Org ID as defined by DHCFP/ Carrier Unique Provider Code	Combined Payer/ Provider ID for de-identified linking. Masked value. Can be linked to masked value in elements with the same combined ID values.			P	Yes
47	PV001/ PV029	Payer / Provider Type Code	256	varbinary	Submitter Org ID as defined by DHCFP/ Provider Type Code (as defined by Carrier)	Use this masked field value to link to the code Description in the **Carrier-Specific Master Lookup Table**			P	Yes
48	PV001/ PV030	Payer / Primary Specialty Code	256	varbinary	Submitter Org ID as defined by DHCFP/ Primary Specialty Code (as defined by Carrier)	Use this masked field value to link to the code Description in the **Carrier-Specific Master Lookup Table**			P	Yes
49	PV001/ PV042	Payer / Secondary Specialty2 Code	256	varbinary	Submitter Org ID as defined by DHCFP/ Specialty Code 2 (as defined by Carrier)	Use this masked field value to link to the code Description in the **Carrier-Specific Master Lookup Table**			P	Yes
50	PV001/ PV043	Payer / Secondary Specialty3 Code	256	varbinary	Submitter Org ID as defined by DHCFP/ Specialty Code 3 (as defined by Carrier)	Use this masked field value to link to the code Description in the **Carrier-Specific Master Lookup Table**			P	Yes
51	PV001/ PV044	Payer / Secondary Specialty4 Code	256	varbinary	Submitter Org ID as defined by DHCFP/ Specialty Code 4 (as defined by Carrier)	Use this masked field value to link to the code Description in the **Carrier-Specific Master Lookup Table**			P	Yes
52	PV001/ PV054	Payer / Medical/Healthcare Home ID	256	varbinary	Submitter Org ID as defined by DHCFP/ Carrier-assigned Medical/Healthcare Home Identification Number	Combined Payer/ Home ID for de-identified linking. Masked value. Can be linked to masked value in elements with the same combined ID values.			P	Yes
53	PV001/ PV056	Payer / Provider Affiliation	256	varbinary	Submitter Org ID as defined by DHCFP/ Carrier-assigned Provider ID for Provider Affiliation	Combined Payer/ Provider ID for de-identified linking. Masked value. Can be linked to masked value in elements with the same combined ID values.			P	Yes
54	Derived by DHCFP	Unique Record ID: Public File	10	int	Unique Record ID - Derived by DHCFP	Unique Record ID for Provider record: Restricted File value matches Public File value for the same record.			P	No

Provider File - Restricted Use Data Elements										
Order	**Element**	**Data Element Name**	**Max Length**	**Data Type Guide**	**Description**	**Release Notes**	**Edit Level**	**APCD Threshold**	**Public / Restricted**	**Masked**
1	PV001	Payer	256	varbinary	Carrier Specific Submitter Code as defined by APCD. This must match the Submitter Code reported in HD002	A Division assigned identifier for any APCD Data Submitter; Insurance, Benefit Manager/Administrator, TPA, Vendor	A0	100%	R	Yes
2	PV002	Plan Provider ID	256	varbinary	Carrier Unique Provider Code	The unique number for every service provider (persons, facilities or other entities involved in claims transactions) that a carrier has in its system. This field may or may not be the provider NPI. This field is used to help uniquely identify a provider and that provider's affiliation and practice location within this file.	A0	100%	R	Yes
3	PV003	Tax Id	256	varbinary	The Federal Tax ID associated with the provider identified in PV002.	Tax ID of the Provider regardless of Entity (Qualifier) Code.	A2	98%	R	Yes
4	PV005	DEA ID	256	varbinary	Primary DEA number for the provider identified in PV002.	The DEA for this provider.	B	98%	R	Yes
5	PV007	Medicaid Id	256	varbinary	Medicaid assigned number for the Provider in PV002	This is the unique State Medicaid ID of the provider reported in this segment.	B	0%	R	Yes
6	PV015/Year	Provider Birth Year	10	int	Provider's date of birth - Year only	Year of the Birth date of the Provider when the Provider is identified as an individual in ProviderID Code (1 = Individual)			R	No
7	PV016	Street Address1 Name	128	varchar	Street address of the Provider	Street address of the Provider Practice Site.	A1	98%	R	No
8	PV017	Street Address2 Name	128	varchar	Secondary Street Address of the Provider	Street address 2 of the Provider Practice Site.	A0	2%	R	No
9	PV035	SSN Id	256	varbinary	Provider's Social Security Number	Tax ID of the Provider when ProviderIDCode = 1 (Person).	A1	98%	R	Yes
10	PV036	Medicare Id	256	varbinary	Provider's Medicare Number	This is the unique Medicare ID of the provider reported in this segment. This can be any of the Medicare IDs; UPIN, OSCAR	B	90%	R	Yes

Provider File - Restricted Use Data Elements										
Order	**Element**	**Data Element Name**	**Max Length**	**Data Type Guide**	**Description**	**Release Notes**	**Edit Level**	**APCD Threshold**	**Public / Restricted**	**Masked**
11	PV054	Medical/Health care Home ID	256	varbinary	Medical Home Identification Number	The carrier assigned ID number of the Patient-centered medical home the provider is linked to	B	0%	R	Yes
12	PV056	Provider Affiliation	256	varbinary	Provider Affiliation Code	The Provider ID for any affiliation the provider has with another entity or parent company. Link to PV002 on the Provider File to obtain detailed attributes of the Affiliated Provider. If the provider is associated only with self, record the same value here as PV002.	B	99%	R	Yes
13	Derived by DHCFP	Unique Record ID: Restricted File		int	Unique Record ID - Derived by DHCFP	Unique Record ID for Provider record: Restricted File value matches Public File value for the same record.			R	No

Provider File - Unavailable Data Elements							
Order	**Element**	**Data Element Name**	**Description**	**Release Notes**	**Edit Level**	**APCD Threshold**	**Public / Restricted**
1	PV004	UPIN Id - GIC Only	Unique Physician Identification Number (UPIN)	Unique Physician ID as defined by Centers Medicare & Medicaid Services (CMS)	B	0%	not released
2	PV015	Provider Date of Birth	Provider's date of birth	Birth date of the Provider when the Provider is identified as an individual in ProviderID Code (1 = Individual)	B	20%	not released
3	PV041	GIC Provider Link ID	GIC Provider Link ID for GIC Carriers only	GIC Provider Link ID for GIC Carriers only	B	0%	not released

Provider File Lookup Tables, by Element										
Order	**Element**	**Data Element Name**	**Max Length**	**Data Type Guide**	**Description**	**Release Notes**	**Edit Level**	**APCD Threshold**	**Public / Restricted**	**Masked**
7	PV013	Entity Code	10	varchar	Provider facility code (Lookup Table)	Numeric indicator that reports the type of facility the carrier or its designee has on file for the provider. When the provider is an individual, 31 (Other) should be reported here.	A0	98%	P	No
					Entity Type	***Type***				
					01	Academic Institution				
					02	Adult Foster Care				
					03	Ambulance Services				
					04	Hospital Based Clinic				
					05	Stand-Alone, Walk-In/Urgent Care Clinic				
					06	Other Clinic				
					07	Community Health Center - General				
					08	Community Health Center - Urgent Care				
					09	Government Agency				
					10	Health Care Corporation				
					11	Home Health Agency				
					12	Acute Hospital				
					13	Chronic Hospital				
					14	Rehabilitation Hospital				
					15	Psychiatric Hospital				
					16	DPH Hospital				
					17	State Hospital				
					18	Veterans Hospital				
					19	DMH Hospital				
					20	Sub-Acute Hospital				

Provider File Lookup Tables, by Element										
Ord-er	**Element**	**Data Element Name**	**Max Length**	**Data Type Guide**	**Description**	**Release Notes**	**Edit Level**	**APCD Thres-hold**	**Public / Restrict-ed**	**Mask-ed**
					21	Licensed Hospital Satellite Emergency Facility				
					22	Hospital Emergency Center				
					23	Nursing Home				
					24	Freestanding Ambulatory Surgery Center				
					25	Hospital Licensed Ambulatory Surgery Center				
					26	Non-Health Corporations				
					27	School Based Health Center				
					28	Rest Home				
					29	Licensed Hospital Satellite Facility				
					30	Hospital Licensed Health Center				
					31	Other				
8	PV014	Gender Code	1	varchar	Gender of Provider (Lookup Table)	A code that defines the Provider's gender when the Provider is identified as an individual in ProviderID Code (1 = Individual)	B	20%	P	No
					Gender Code	***Gender***				
					F	Female				
					M	Male				
					O	Other				
					U	Unknown				
22	PV034	ProviderID Code	5	varchar	Provider Identification Code (Lookup Table)	Numeric code that reports the type of entity associated with the Plan Provider ID	A0	100%	P	No
					Entity Qualifier Code	***Entity Qualifier***				
					1	Person; physician, clinician, orthodontist, and any individual that is licensed/certified to perform health care services.				

Provider File Lookup Tables, by Element										
Ord-er	**Element**	**Data Element Name**	**Max Length**	**Data Type Guide**	**Description**	**Release Notes**	**Edit Level**	**APCD Thres-hold**	**Public / Restrict-ed**	**Mask-ed**
					2	Facility; hospital, health center, long term care, rehabilitation and any building that is licensed to transact health care services.				
					3	Professional Group; collection of licensed/certified health care professionals that are practicing health care services under the same entity name and Federal Tax Identification Number.				
					4	Retail Site; brick-and-mortar licensed/certified place of transaction that is not solely a health care entity, i.e., pharmacies, independent laboratories, vision services.				
					5	E-Site; internet-based order/logistic system of health care services, typically in the form of durable medical equipment, pharmacy or vision services. Address assigned should be the address of the company delivering services or order fulfillment.				
					6	Financial Parent; financial governing body that does not perform health care services itself but directs and finances health care service entities, usually through a Board of Directors.				
					7	Transportation; any form of transport that conveys a patient to/from a healthcare provider.				
					0	Other; any type of entity not otherwise defined that performs health care services.				

Provider File Lookup Tables, by Element										
Order	**Element**	**Data Element Name**	**Max Length**	**Data Type Guide**	**Description**	**Release Notes**	**Edit Level**	**APCD Threshold**	**Public / Restricted**	**Masked**
30	PV045	P4PFlag	1	varchar	Pay-for-Performance (P4P) indicator (Lookup Table)	Numeric indicator that reports if the provider has a Pay-for-Performance agreement with the carrier, or its designee, for the time-period on this provider segment.	B	100%	P	No
					Value	***Description***				
					1	Yes				
					2	No				
					3	Unknown				
					4	Other				
					5	Not Applicable				
31	PV046	NonClaims Flag	1	varchar	Non-claims Financial Transaction Indicator (Lookup Table)	Numeric indicator that reports if the provider received non-claims based payments during the time-period of this provider segment.	B	100%	P	No
					Value	***Description***				
					1	Yes				
					2	No				
					3	Unknown				
					4	Other				
					5	Not Applicable				
32	PV047	Uses Electronic Medical Records	1	varchar	Provider Uses EMR indicator (Lookup Table)	Numeric indicator that reports if the provider utilized electronic medical records during the time-period reported on this provider segment.	B	100%	P	No
					Value	***Description***				
					1	Yes				
					2	No				
					3	Unknown				

Provider File Lookup Tables, by Element										
Order	**Element**	**Data Element Name**	**Max Length**	**Data Type Guide**	**Description**	**Release Notes**	**Edit Level**	**APCD Threshold**	**Public / Restricted**	**Masked**
					4	Other				
					5	Not Applicable				
34	PV049	Accepting New Patients	1	varchar	Indicates if provider or provider group is accepting new patients as it applies to this carrier's products/plans. (Lookup Table)	Numeric indicator that reports if the provider is accepting new Patients/cases during the time-period reported on this provider segment.	B	100%	P	No
					Value	***Description***				
					1	Yes				
					2	No				
					3	Unknown				
					4	Other				
					5	Not Applicable				
35	PV050	Offers e-Visits	1	varchar	Indicates if the provider uses eVisit tools (web based software) for well visits. (Lookup Table)	Numeric indicator that reports if the provider offers e-Visits.	C		P	No
					Value	***Description***				
					1	Yes				
					2	No				
					3	Unknown				
					4	Other				
					5	Not Applicable				
36	PV052	Has multiple offices	1	varchar	Indicates if the provider has multiple office locations where it sees patients (Lookup Table)	Flag indicating if the provider has more than one practice site	A0	100%	P	No
					Value	***Description***				

Provider File Lookup Tables, by Element										
Ord-er	**Element**	**Data Element Name**	**Max Length**	**Data Type Guide**	**Description**	**Release Notes**	**Edit Level**	**APCD Thres-hold**	**Public / Restrict-ed**	**Mask-ed**
					1	Yes				
					2	No				
					3	Unknown				
					4	Other				
					5	Not Applicable				
37	PV055	PCP Flag	1	varchar	Indicates if the provider is a PCP. For Facilities or entities where this is not applicable, value of N (No) is allowed. (Lookup Table)	Numeric indicator that reports if the provider (persons only) is a Primary Care Provider during the time-period of this provider segment.	A0	100%	P	No
					Value	***Description***				
					1	Yes				
					2	No				
					3	Unknown				
					4	Other				
					5	Not Applicable				
39	PV058	Delegated Provider Record Flag	1	varchar	Provider Record Source Indicator (Lookup Table)	Numeric indicator that reports if the provider record was sourced from a delegated provider system.	B	100%	P	No
					Value	***Description***				
					1	Yes				
					2	No				
					3	Unknown				
					4	Other				
					5	Not Applicable				

Provider File Lookup Tables, by Element										
Ord-er	**Element**	**Data Element Name**	**Max Length**	**Data Type Guide**	**Description**	**Release Notes**	**Edit Level**	**APCD Thres-hold**	**Public / Restrict-ed**	**Mask-ed**
40	PV060	Office Type	1	varchar	Office Type Code (Lookup Table)	Numeric indicator that reports the type of office the provider is associated with in this provider segment.	A0	95%	P	No
					Office Type Code	***Office Type***				
					1	Facility				
					2	Doctors office				
					3	Clinic				
					4	Walk in Clinic				
					5	Laboratory				
					0	Other				
41	PV061	Prescribing Provider	1	varchar	Prescribing privilege indicator (Lookup Table)	Numeric indicator that reports if the provider has prescribing privileges during the time-period on this provider segment.	C	100%	P	No
					Value	***Description***				
					1	Yes				
					2	No				
					3	Unknown				
					4	Other				
					5	Not Applicable				
44	PV064	PPO Indicator	1	varchar	Indicates if the provider is a contracted provider (Lookup Table)	Numeric indicator that reports if the provider is a Preferred Provider Organization during the time-period reported on this provider segment.	A0	100%	P	No
					Value	***Description***				
					1	Yes				
					2	No				
					3	Unknown				
					4	Other				

Provider File Lookup Tables, by Element										
Ord-er	**Element**	**Data Element Name**	**Max Length**	**Data Type Guide**	**Description**	**Release Notes**	**Edit Level**	**APCD Thres-hold**	**Public / Restrict-ed**	**Mask-ed**
					5	Not Applicable				

Provider File: External Code Sources

Refer to Appendix 2 in this document: External Code Sources

LOOKUP TABLES AND CARRIER-SPECIFIC INFORMATION

Element-Specific vs. Carrier-Specific Lookup Tables

- In the File Layout section, **element-specific lookup tables** are included for a number of data elements for each File Type. These lookup tables apply to **all Carriers**. The lookup tables are not included in the 10/31/2012 APCD Data Release files but **are only listed in this document**.
- Some data elements have **carrier-specific lookup tables**, because the lookup codes and descriptions are different for each carrier. The Carrier Org ID is a restricted and masked element. Therefore, for these data elements, the code found in the field is a Masked Combined element which is comprised of the Org ID and the Lookup Code. The Descriptions for these codes are found in the **Master Lookup Table**.

Carrier-Specific Master Lookup Table

The **Master Lookup Table** containing **carrier-specific reference data** is included with the **10/31/2012 APCD Data Release**.

- This table includes a combined masked element for the Org ID / Lookup Code, because the Carrier Org ID is a masked element in the data release.

The Master Lookup table includes the following columns:

Column Name	Description
File Type:	MC,PV, ME,DC
Data Element:	Data Elements included are: DC026, MC032, MC080, MC124, MC132, ME076, PV029, PV030, PV042, PV043, PV044
Combined Masked Element: Org ID/Code	This field contains values for two Data Elements that are Combined and then masked: • Carrier Specific Submitter Code as defined by APCD (Payer Org ID) • Data Element Value (Lookup Code) **There is a row in the Master Lookup table for each Data Element/Org ID/existing Lookup Code**
Description:	This field contains the **Carrier-Specific Description** for the Org ID and Lookup Code **NOTE:** In the 10/31/2012 APCD Data Release, the field descriptions for MC080 (Reason for Adjustment), MC124 (Denial Reason) and some of the records related to MC032, contain the following: '**Description withheld by DHCFP pending data cleansing.**' Confidential data was discovered in these field descriptions so they have been redacted from the release.

In order to provide **linkage** between the **Carrier-Specific Master Lookup Table** and the **APCD data**, the following fields have been added to the indicated APCD Files. Refer to the **Linkage** section in this document for more information:

Combination Masked fields:

Dental:	
DC001 /DC026 :	Payer/Service Provider Specialty
Medical:	
MC001/MC032 :	Payer/ Service Provider Specialty

MC001 /MC080 :	Payer/Reason for Adjustment NOTE: Description redacted for 10/31/2012 release due to confidentiality issue.
MC001/MC124 :	Payer/ Denial Reason NOTE: Description redacted for 10/31/2012 release due to confidentiality issue.
MC001 /MC132 :	Payer/Service Class
Eligibility:	
ME001/ME076 :	Payer/ Member Rating Category
Provider:	
PV001/PV029 :	Payer/ Provider Type Code
PV001/PV030 :	Payer/ Primary Specialty Code
PV001/PV042 :	Payer/ Secondary Specialty2 Code
PV001/PV043 :	Payer/ Secondary Specialty3 Code
PV001/PV044:	Payer / Secondary Specialty4 Code

DATA PROTECTION/CONFIDENTIALITY

The Division is charged with protecting the confidentiality of individuals and organizations contributing data to the APCD. This requirement extends to customers of the APCD Data Release as well (refer to the language in the Data Release regulation quoted in the Introduction to this document).

Masked Data Elements and Linking

In order to comply with confidentiality requirements for APCD data, the Division has applied masking procedures on certain APCD Data Elements prior to release. (Masked elements are marked 'Yes' in the 'Masked' column in the File Layout section of this document.)

Masking is introduced to protect the privacy of individuals and organizations. At the same time, in order for the data to be useful for research, it is necessary to provide links between Claims, Products, Member Eligibility, and Providers.

Masking Confidential Data

- As a part of Carrier Submission processing, confidential data elements such as personal and organizational identifiers are stored at the Division in an **encrypted** state.
- Some of these confidential data elements are **masked for the APCD Data Release** (refer to the File Layout section).
    - Masking a data element's field contents produces a 256-character-maximum text field.
    - Masked data elements always "mask the same way", so that while the field contents are not recognizable, the masked value **can be linked** to an element containing the same masked value in another Claim, or in a Provider, Product, or Member Eligibility record.
- Some masked data elements are in the **Restricted Access group only** (for example, the **Carrier Org ID**). These elements will be released masked, and **only** to successful Restricted Access candidates.
    - For **Public Use File** users, this requirement creates a **linking issue** for researchers, as without a link to a Carrier, **masked carrier-specific identifiers** for individuals, claims, products and providers could appear to be falsely linked to the same identifier used by another Carrier for another individual, claim, product, or provider.
    - **Masked Combined Data Elements** have been created by the Division for the Public Use files, to provide a way to group related records while maintaining confidentiality.

Masked Combined Data Elements Introduced for Linkage

In order to provide a **Carrier-specific linking method** for Public Release files, combined/masked fields have been added to the database that will uniquely identify and link masked confidential elements within a masked Carrier group.

- The Combined fields added for this purpose are each a combination of the Carrier Org Id and one other data element, such as Plan Provider ID, Member ID, Product ID, or other carrier-specific identifier. The two values are combined and then masked, providing a unique value specific to a Carrier. Refer to the **Linkage** section for descriptions of these elements.

Null Values

- As a part of Carrier Submission processing, any data elements filed by Carriers with a length of zero are stored as **'Null'** in the APCD database.
- Null values are excluded from masking, to eliminate a possible result of false linking due to masked Null values that appear to match.
- Any Null values found in Masked fields (including either part of a combined masked field) will produce an empty field in the Release files.

LINKAGE

Linking between Public and Restricted files

One of two data elements, **Unique Record ID: Restricted File** or **Unique Record ID: Public File,** is included in **every APCD Data Release row** (these fields contain the **same value** for a single APCD record divided into Public and Restricted files). This identifier provides the means to link the Public Data Elements with the Restricted Data Elements for the same record in the APCD Database. There is a unique identifier for **each row, in each File Type/Year**.

Linking Across Files Using Masked Combined Elements

The following tables list the **masked combined elements** added to the **APCD Release Database** for the purpose of **linking between claims and other APCD files**, without violation of confidentiality.

Please note the ability to link across files using the data elements below is limited by the amount of valid data within the preliminary data.

The following tables are organized by the **type of Lookup or Identifier** being combined and masked with the Payer Org ID.

Carrier-Specific Master Lookup - Linking Elements								
File	**P/R**	**Rel Col**	**Element**	**Type of Data Masked with Submitter Org ID for cross-file reference**	**Combined Data Element Name**	**Description**	**Release Notes**	**Edit Levels of combined elements**
ME	R	23	ME001 / ME076	**Master Lookup: Member Rating Category Code**	Payer / Member rating category	Submitter Org ID as defined by DHCFP/ Member Rating Category Code (as defined by Carrier)	Use this masked field value to link to the Description in the **Carrier-Specific Master Lookup Table**	A0 / B
PV	P	47	PV001/ PV029	**Master Lookup: Provider Type Code**	Payer / Provider Type Code	Submitter Org ID as defined by DHCFP/ Provider Type Code (as defined by Carrier)	Use this masked field value to link to the Description in the **Carrier-Specific Master Lookup Table**	A0 / A1
MC	R	42	MC001 / MC080	**Master Lookup: Reason for Adjustment**	Payer / Reason for Adjustment	Submitter Org ID as defined by DHCFP/ Reason for Adjustment Code (as defined by Carrier)	Use this masked field value to link to the Description in the **Carrier-Specific Master Lookup Table. NOTE:** Description redacted for 10/31/2012 release due to confidentiality issue.	A0 / A1
MC	R	43	MC001 / MC124	**Master Lookup: Reason for Denial**	Payer / Denial Reason	Submitter Org ID as defined by DHCFP/ Denial Reason Code (as defined by Carrier)	Use this masked field value to link to the Description in the **Carrier-Specific Master Lookup Table. NOTE:** Description redacted for 10/31/2012 release due to confidentiality issue.	A0 / B
MC	P	103	MC001 / MC132	**Master Lookup: Service Class**	Payer / Service Class	Submitter Org ID as defined by DHCFP/ Service Class Code (as defined by Carrier)	Use this masked field value to link to the Description in the **Carrier-Specific Master Lookup Table**	A0 / C

Carrier-Specific Master Lookup - Linking Elements								
File	**P/R**	**Rel Col**	**Element**	**Type of Data Masked with Submitter Org ID for cross-file reference**	**Combined Data Element Name**	**Description**	**Release Notes**	**Edit Levels of combined elements**
DC	P	33	DC001 / DC026	**Master Lookup: Specialty Code**	Payer / Service Provider Specialty	Submitter Org ID as defined by DHCFP/ Service Provider Specialty Code (as defined by Carrier)	Use this masked field value to link to the Description in the **Carrier-Specific Master Lookup Table**	A / B
MC	P	97	MC001 / MC032	**Master Lookup: Specialty Code**	Payer/Service Provider Specialty	Submitter Org ID as defined by DHCFP/ Service Provider Specialty Code (as defined by Carrier)	Use this masked field value to link to the Description in the **Carrier-Specific Master Lookup Table**	A0 / B
PV	P	48	PV001/ PV030	**Master Lookup: Specialty Code**	Payer / Primary Specialty Code	Submitter Org ID as defined by DHCFP/ Primary Specialty Code (as defined by Carrier)	Use this masked field value to link to the Description in the **Carrier-Specific Master Lookup Table**	A0 / B
PV	P	49	PV001/ PV042	**Master Lookup: Specialty Code**	Payer / Secondary Specialty2 Code	Submitter Org ID as defined by DHCFP/ Specialty Code 2 (as defined by Carrier)	Use this masked field value to link to the Description in the **Carrier-Specific Master Lookup Table**	A0 / B
PV	P	50	PV001/ PV043	**Master Lookup: Specialty Code**	Payer / Secondary Specialty3 Code	Submitter Org ID as defined by DHCFP/ Specialty Code 3 (as defined by Carrier)	Use this masked field value to link to the Description in the **Carrier-Specific Master Lookup Table**	A0 / B
PV	P	51	PV001/ PV044	**Master Lookup: Specialty Code**	Payer / Secondary Specialty4 Code	Submitter Org ID as defined by DHCFP/ Specialty Code 4 (as defined by Carrier)	Use this masked field value to link to the Description in the **Carrier-Specific Master Lookup Table**	A0 / B

Member ID - Linking Elements								
File	**P/R**	**Rel Col**	**Element**	**Type of Data masked with Submitter Org ID for cross-file reference**	**Combined Data Element Name**	**Description**	**Release Notes**	**Edit Levels of combined elements**
DC	P	35	DC001 / DC056	**Member ID (Dental)**	Payer / Carrier-Specific Unique Member ID	Submitter Org ID as defined by DHCFP/ Carrier-assigned Member/Patient Unique ID	Masked value. Can be linked to masked value in elements with the same combined ID values.	A0 / A0
MC	P	106	MC001 / MC137	**Member ID (Medical)**	Payer / Carrier-Specific Unique Member ID	Submitter Org ID as defined by DHCFP/ Carrier-assigned Member/Patient Unique ID	Masked value. Can be linked to masked value in elements with the same combined ID values.	A0 / A0

Member ID - Linking Elements								
File	**P/R**	**Rel Col**	**Element**	**Type of Data masked with Submitter Org ID for cross-file reference**	**Combined Data Element Name**	**Description**	**Release Notes**	**Edit Levels of combined elements**
ME	P	53	ME001 / ME107	**Member ID (Member)**	Payer / Carrier-Specific Unique Member ID	Submitter Org ID as defined by DHCFP/ Carrier-assigned Member/Patient Unique ID	Masked value. Can be linked to masked value in elements with the same combined ID values.	A0 / A0
PC	P	55	PC001 / PC107	**Member ID (Pharmacy)**	Payer / Carrier-Specific Unique Member ID	Submitter Org ID as defined by DHCFP/ Carrier-assigned Member/Patient Unique ID	Masked value. Can be linked to masked value in elements with the same combined ID values.	A0 / A0

Delegated Benefit Administrator - Linking Elements								
File	**P/R**	**Rel Col**	**Element**	**Type of Data masked with Submitter Org ID for cross-file reference**	**Combined Data Element Name**	**Description**	**Release Notes**	**Edit Levels of combined elements**
DC	P	32	DC001 / DC025	**Org ID as defined by DHCFP (Dental Delegated Benefit Administrator ID)**	Payer / Delegated Benefit Administrator Organization ID	Submitter Org ID as defined by DHCFP/ DHCFP assigned Org ID for Benefit Administrator	Masked value. Can be linked to masked value in elements with the same combined ID values.	A0 / C
MC	P	100	MC001 / MC100	**Org ID as defined by DHCFP (Medical Delegated Benefit Administrator ID)**	Payer / Delegated Benefit Administrator Organization ID	Submitter Org ID as defined by DHCFP/ DHCFP assigned Org ID for Delegated Benefit Administrator	Masked value. Can be linked to masked value in elements with the same combined ID values.	A0 / C
PC	P	54	PC001 / PC072	**Org ID as defined by DHCFP (Pharmacy Delegated Benefit Administrator ID)**	Payer / Delegated Benefit Administrator Organization ID	Submitter Org ID as defined by DHCFP/ DHCFP assigned Org ID for Benefit Administrator	Masked value. Can be linked to masked value in elements with the same combined ID values.	A0 / C

Product ID - Linking Elements								
File	**P/R**	**Rel Col**	**Element**	**Type of Data masked with Submitter Org ID for cross-file reference**	**Combined Data Element Name**	**Description**	**Release Notes**	**Edit Levels of combined elements**
DC	P	34	DC001 / DC042	**Product ID (Dental)**	Payer / Product ID Number	Submitter Org ID as defined by DHCFP/ Product Identification Number	Masked value. Can be linked to masked value in elements with the same combined ID values.	A0 / A0
MC	P	99	MC001 / MC079	**Product ID (Medical)**	Payer / Product ID Number	Submitter Org ID as defined by DHCFP/ Product Identification Number	Masked value. Can be linked to masked value in elements with the same combined ID values.	A0 / A0
ME	P	52	ME001 / ME040	**Product ID (Member)**	Payer / Product ID Number	Submitter Org ID as defined by DHCFP/ Product Identification Number	Masked value. Can be linked to masked value in elements with the same combined ID values.	A0 / A0
PC	P	52	PC001 / PC056	**Product ID (Pharmacy)**	Payer / Product ID Number	Submitter Org ID as defined by DHCFP/ Product Identification Number	Masked value. Can be linked to masked value in elements with the same combined ID values.	A0 / A0
PR	P	8	HD002/ PR001	**Product ID (Plan)**	Payer / Product ID	Header Submitter Org ID as defined by DHCFP/Carrier ID/ Product Identification Number	Masked value. Can be linked to masked value in elements with the same combined ID values.	A0 / A0

Provider ID - Linking Elements								
File	**P/R**	**Rel Col**	**Element**	**Type of Data masked with Submitter Org ID for cross-file reference**	**Combined Data Element Name**	**Description**	**Release Notes**	**Edit Levels of combined elements**
PV	P	53	PV001/ PV056	**Provider ID (Affiliation)**	Payer / Provider Affiliation	Submitter Org ID as defined by DHCFP/ Carrier-assigned Provider ID for Provider Affiliation	Masked value. Can be linked to masked value in elements with the same combined ID values.	A0 / B

Provider ID - Linking Elements								
File	**P/R**	**Rel Col**	**Element**	**Type of Data masked with Submitter Org ID for cross-file reference**	**Combined Data Element Name**	**Description**	**Release Notes**	**Edit Levels of combined elements**
MC	P	102	MC001 / MC125	**Provider ID (Attending)**	Payer / Attending Provider	Submitter Org ID as defined by DHCFP/ Attending Provider ID number found in the Provider File (PV002). This number is defined in the carrier's systems and may be equal to any other identifier, i.e., NPI, State License Number	Masked value. Can be linked to masked value in elements with the same combined ID values.	A0 / A1
MC	P	98	MC001 / MC076	**Provider ID (Billing)**	Payer / Billing Provider Number	Submitter Org ID as defined by DHCFP/ Billing Provider Number	Masked value. Can be linked to masked value in elements with the same combined ID values.	A0 / B
DC	P	31	DC001 / DC018	**Provider ID (Dental Service)**	Payer / Service Provider Number	Submitter Org ID as defined by DHCFP/ Service Provider Identification Number	Masked value. Can be linked to masked value in elements with the same combined ID values.	A0 / A1
ME	P	51	ME001 / ME036	**Provider ID (Health Care Home ID)**	Payer / Health Care Home Number	Submitter Org ID as defined by DHCFP/ Carrier-assigned Provider ID for Health Care Home	Masked value. Can be linked to masked value in elements with the same combined ID values.	A0 / C
PV	P	52	PV001/ PV054	**Provider ID (Health Care Home ID)**	Payer / Medical/Healthcare Home ID	Submitter Org ID as defined by DHCFP/ Carrier-assigned Medical/Healthcare Home Identification Number	Masked value. Can be linked to masked value in elements with the same combined ID values.	A0 / B
MC	P	104	MC001 / MC134	**Provider ID (Medical Plan Rendering)**	Payer / Plan Rendering Provider Identifier	Submitter Org ID as defined by DHCFP/ Plan Rendering Provider ID	Masked value. Can be linked to masked value in elements with the same combined ID values.	A0 / A0
MC	P	105	MC001 / MC135	**Provider ID (Medical Provider Location)**	Payer / Provider Location	Submitter Org ID as defined by DHCFP as defined by DHCFP/ Location of Provider	Masked value. Can be linked to masked value in elements with the same combined ID values.	A0 / B
MC	P	96	MC001 / MC024	**Provider ID (Medical Service)**	Payer / Service Provider Number	Submitter Org ID as defined by DHCFP/ Service Provider Identification Number	Masked value. Can be linked to masked value in elements with the same combined ID values.	A0 / A1
ME	R	22	ME001 / ME046	**Provider ID (PCP)**	Payer / Member PCP ID	Submitter Org ID as defined by DHCFP/ Member's Carrier-Defined PCP ID	Masked value. Can be linked to masked value in elements with the same combined ID values.	A0 / B

Provider ID - Linking Elements								
File	**P/R**	**Rel Col**	**Element**	**Type of Data masked with Submitter Org ID for cross-file reference**	**Combined Data Element Name**	**Description**	**Release Notes**	**Edit Levels of combined elements**
PC	P	53	PC001 / PC059	**Provider ID (PCP)**	Payer / Recipient PCP ID	Submitter Org ID as defined by DHCFP/ Member/Patient's Carrier-defined PCP ID	Masked value. Can be linked to masked value in elements with the same combined ID values.	A0 / B
PC	P	50	PC001 / PC018	**Provider ID (Pharmacy NCPDP or NABP ID)**	Payer / Pharmacy Number	Submitter Org ID as defined by DHCFP/ Pharmacy NCPDP or NABP ID	Masked value. Can be linked to masked value in elements with the same combined ID values.	A0 / A0
PV	P	46	PV001/ PV002	**Provider ID (Plan Provider ID)**	Payer / Plan Provider ID	Submitter Org ID as defined by DHCFP/ Carrier Unique Provider Code	Masked value. Can be linked to masked value in elements with the same combined ID values.	A0 / A0
PC	P	51	PC001 / PC043	**Provider ID (Prescribing)**	Payer / Prescribing ProviderID	Submitter Org ID as defined by DHCFP/ Prescribing Provider Number	Masked value. Can be linked to masked value in elements with the same combined ID values.	A0 / A0
MC	P	101	MC001 / MC112	**Provider ID (Referring)**	Payer / Referring Provider ID	Submitter Org ID as defined by DHCFP/ Referring Provider Number	Masked value. Can be linked to masked value in elements with the same combined ID values.	A0 / B

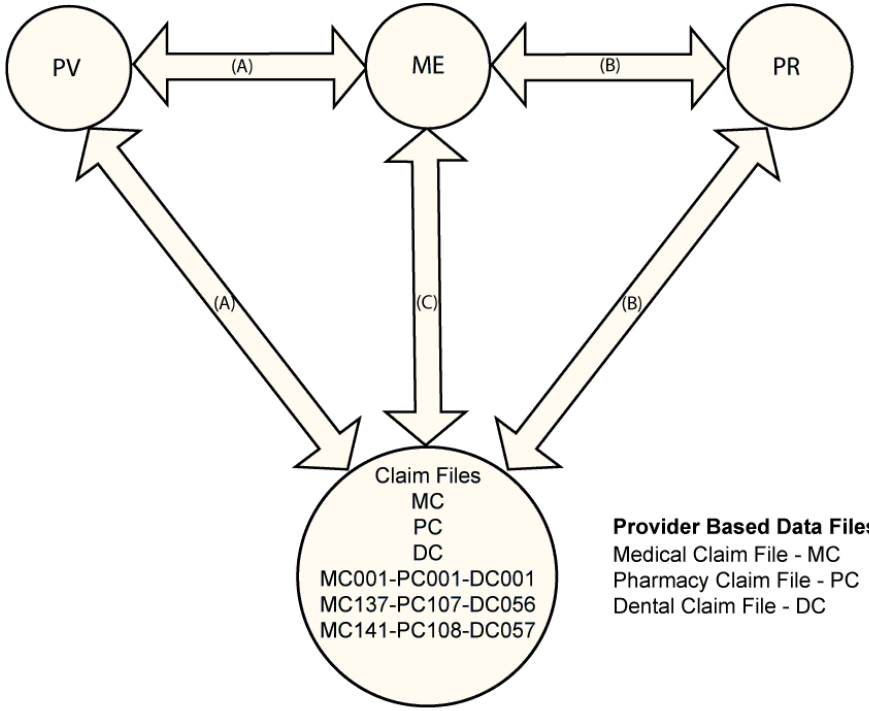
Subscriber ID - Linking Elements								
File	**P/R**	**Rel Col**	**Element**	**Type of Data masked with Submitter Org ID for cross-file reference**	**Combined Data Element Name**	**Description**	**Release Notes**	**Edit Levels of combined elements**
DC	P	36	DC001 / DC057	**SubscriberID (Dental)**	Payer / CarrierSpecificUniqueSubscriberID	Submitter Org ID as defined by DHCFP/ Subscriber Carrier Unique Identification	Masked value. Can be linked to masked value in elements with the same combined ID values.	A0 / A0
MC	P	107	MC001 / MC141	**SubscriberID (Medical)**	Payer / CarrierSpecificUnique SubscriberID	Submitter Org ID as defined by DHCFP/ Subscriber Carrier Unique Identification	Masked value. Can be linked to masked value in elements with the same combined ID values.	A0 / A0
ME	P	54	ME001 / ME117	**SubscriberID (Member)**	Payer / CarrierSpecificUnique SubscriberID	Submitter Org ID as defined by DHCFP/ Subscriber Carrier Unique Identification	Masked value. Can be linked to masked value in elements with the same combined ID values.	A0 / A0

Subscriber ID - Linking Elements								
File	**P/R**	**Rel Col**	**Element**	**Type of Data masked with Submitter Org ID for cross-file reference**	**Combined Data Element Name**	**Description**	**Release Notes**	**Edit Levels of combined elements**
PC	P	56	PC001 / PC108	**SubscriberID (Pharmacy)**	Payer / CarrierSpecificUnique SubscriberID	Submitter Org ID as defined by DHCFP/ Subscriber Carrier Unique Identification	Masked value. Can be linked to masked value in elements with the same combined ID values.	A0 / A0

APCD Cross-File Relationships

The following analysis does not take into account any APCD Data Release restrictions, masking, or edit levels. It is included here for reference only:

Carriers Based Data Files
Product File - PR
Member Eligibility File - ME
Provider File - PV



Provider Based Data Files
Medical Claim File - MC
Pharmacy Claim File - PC
Dental Claim File - DC

PV001- Payer
PV002 – Plan Provider ID
PV039 – National Provider ID
PV040 – National Provider2 ID
PR001 – Product ID Number
ME001 - Payer
ME036 – Health Care Home Number
ME038 – Health Care Home National Provider ID
ME040 – Product ID Number
ME046 – Member PCP ID
ME107 - CarrierSpecificUniqueMemberID
ME117 – CarrierSpecificUniqueSubscriberID
MC001 – Payer
MC024 – Service Provider Number
MC026 – National Service Provider ID
MC076 – Billing Provider Number
MC077 – National Billing Provider ID
MC079 – Product ID Number
MC112 – Referring Provider ID
MC125 – Attending Provider
MC134 – Plan Rendering Provider Identifier
MC135 – Provider Location
MC137 – CarrierSpecificUniqueMemberID
MC141 – CarrierSpecificUniqueSubscriberID
PC001 – Payer
PC043 – Prescribing ProviderID
PC048 – Prescribing Physician NPI
PC050 – Prescribing Physician License Number
PC056 – Provider ID Number
PC059 – Recipient PCP ID
DC001 – Payer
DC018 – Service Provider Number
DC020 – National Service Provider ID
DC042 – Product ID Number
DC056 – CarrierSpecificUniqueMemberID
DC057 - CarrierSpecificUniqueSubscriberID

PV-ME; PV-MC; PV-PC; PV-DC (A)
PV001 - ME001
PV002 - ME036, ME046
PV039, PV040 - ME038
PV001 - MC001
PV002 - MC024, MC026, MC076, MC077, MC112,MC125,MC134, MC135
PV039,PV040 - MC026
PV001 - PC001
PV002 - PC043, PC048, PC050, PC059
PV039, PV040 - PC048
PV001 - DC001
PV002 - DC018
PV039, PV040 - DC020

PR-ME; PR-MC; PR-PC; PV-DC (B)
PR001 - ME040
PR001 - MC079
PR001 - PC056
PR001 - DC042

ME-MC; ME-PC; ME-DC; (C)
ME001 - MC001
ME107 - MC137
ME117 - MC141
ME001 - PC001
ME107 - PC107
ME117 - PC108
ME001 - DC001
ME107 - DC056
ME117 - DC057

ME, PR, PV, MC, DC, PC
linkage V1

Date: April 29, 2011

DIVISION OF
Health Care
Finance and Policy

VERSIONING

APCD Medical Claim Versioning

Accurate **Versioning** of **APCD Claim Lines** is necessary to allow researchers to include only the **final version** of each claim line when analyzing claims data. **Final Version Flag** has been added to the release data to help to achieve this.

Prior to the release of APCD Data, a Versioning Process is run on each Claims file. The versioning of APCD Claims involves as many steps as necessary to refine as many claim lines as possible into a final version.

Cleaning

There are known issues in the APCD submitted data, which require cleaning in order to properly version APCD claims. Any data items that need to be cleaned are accounted for by claim line, so that we know exactly which lines were altered. **The values are altered for the Versioning Process only. The data that remains in the Release database will remain as filed by the Payers.** The only flag added to the Release database is the Final Version Flag.

The element used to identify the action applied by the payer for Medical Claims is **MC138 – Claim Line Type**. For this element payers can select from a lookup table with five values to define an adjudication action:

MC138 – Claim Line Type	
O	Original
V	Void
R	Replacement
B	Back Out
A	Amendment

Below is a table outlining the cleaning methods applied.

Issue#	**Cleaning Issue**	**Remedy**
1	Some carriers have spelled out **Original** and **Amendment** in the Claim Line Type field **(DC059).**	Any record with a Claim Line Type "**Original**" will be changed to "**O**". Any record with a Claim Line Type "**Amendment**" will be changed to "**A**".
2	Some carriers are sending **negative values** with claim lines coded with Claim Line Types of "**R**" and "**A**" **(MC138).**	The value is changed from **R to V**, and from **empty or A to B** when the charge amount is **negative**.

Resolving Duplicates

The resolution of duplicates is critical in refining claims lines to the final version. Claim lines can be submitted with duplicative data that would result in several claim lines achieving "final version" status when in fact they are a duplicate claim. Below is a table outlining the duplicate claim resolution methodologies applied.

Critical Versioning Fields (Data Elements used to identify duplicates):	
MC001	Org ID
MC004	Payer Claim Control Number
MC005	Line Counter
MC005A	Version Number
MC138	Claim Line Type
MC055	Procedure Code
MC054	Revenue Code
MC094	Type Of Claim
MC038	Claim Status
MC062	Charge Amount
MC059	Date Of Service From
MC137	Carrier Specific Unique Member Id
MC139	Former Claim Number
Derived by DHCFP	Unique Record ID - assigned by DHCFP to each Claim Line

Issue#	Criteria / Resolution
1	**Duplicate Criteria:** Some organizations are sending duplicate claim lines based on our critical versioning fields: • More than one row exists with **all critical versioning fields matching** except the internal control number Unique Record ID. **Resolution:** Of the group of duplicated claim lines, the row in which the **Unique Record ID has the highest number** is considered the most recently submitted row. The remaining claim lines in the group of duplicate rows are flagged as Duplicates. These rows are not considered for the Final Version of the claim line.

Issue#	Criteria / Resolution
2	**Duplicate Criteria:** More than one row exists with **all critical fields matching** except the **Unique Record ID** and the **Version Number**. • The duplicates sometimes had a different version number; this field does not impact our definition of duplicate. **Resolution:** Of the group of duplicated claim lines, the row in which the **Unique Record ID has the highest number** is considered the most recently submitted row. The remaining claim lines in the group of duplicate rows are flagged as Duplicates. These rows are not considered for the Final Version of the claim line.

Voids and Back Outs

The resolution of **Voids** and **Back Outs** is critical in refining claim lines to the final version, since claim lines can be submitted that are intended to **void or back out a previously submitted claim**. The failure of voids and back outs to capture the claim line intended to be voided or backed out could result in duplicative data that would result in several claim lines achieving "final version" status when in fact they are duplicates. Below is a table outlining the **void and back out claim resolution methodology** applied.

Void and Back Out Methodology
Flag as Voided any claim line that **matches** a **Void** or **Back Out** based on the following fields: **MC001** Payer (Org ID) **MC004** Payer Claim Control Number **MC137** Carrier Specific Unique Member ID **MC055** Procedure Code **MC059** Date Of Service From **MC054** Revenue Code **MC094** Type of Claim **MC062** Charge Amount where the **Void** or **Back Out** was processed **after** the **claim** line to be voided or backed out (i.e., the internal **Unique Record ID** is higher).

Replacements and Amendments

The resolution of replacements and amendments is critical in refining claim lines to the final version since claim lines can be submitted that are intended to **replace or amend out a previously submitted claim**. The failure of replacements and amendments to capture the claim line intended could result in duplicative data that would result in several claim lines achieving "final version" status when in fact they are duplicates. Below is a table outlining the **replacement and amendment claim resolution methodology** applied.

Replacement and Amendment Methodology
Flag as Replaced any claim line that **matches** a **Replacement** or **Amendment** based on the following fields:

MC001	**Payer (Org ID)**
MC004	**Payer Claim Control Number**
MC137	**Carrier Specific Unique Member ID**
MC055	**Procedure Code**
MC059	**Date Of Service From**
MC054	**Revenue Code**
MC094	**Type of Claim**
MC062	**Charge Amount**

where the **Replacement** or **Amendment** was processed **after** the claim line to be replaced or amended (i.e., the internal **Unique Record ID** is higher).

Setting the Final Version

The setting of the claim line **Final Version flag** is the last step in the versioning process and is intended to flag the claim line considered the final version based on the results of the previous steps.

The element used to aid with setting **final version** is **MC038 – Claim Status**. This element is a lookup table with eight values that a payer can select from in order to define an adjudication outcome. The values used are from the standard logic applied by the HIPAA Transaction Set.

DC031 – Claim Status Values	
01	Processed as Primary
02	Processed as Secondary
03	Processed as Tertiary (or any later payer)
04	**Denied**
19	Processed as Primary and forwarded to other payer
20	Processed as Secondary and forwarded to other payer
21	Processed as Tertiary and forwarded to other payer
22	**Reversal of previous payment**

The two values above that are highlighted indicate the values that report a **denial** of the line item or the **reversal of payment**.

Final Version Methodology
Set to **Final Version** any **claim line** where: • **Claim Line Type** is **not Void or Back Out, and** • Claim is **not flagged as Voided**, **Replaced**, **or Duplicate** • **Claim Status value is not 04 or 22** • **Type of Claim** is **'001','002','003','1','2' or '3'** **Potential Claim Line Types** for **Final Version Flag** are**:**

O	**Original**
R	**Replacement**
A	**Amendment**

Flags used in the Versioning Process are:

- **Final Version Flag**
- **Duplicate Flag**
- **Voided Flag**
- **Replaced Flag**

Only the **Final Version Flag** will be reported in the **APCD Data Release**.

APCD Dental Claim Versioning

Accurate **Versioning** of **APCD Claim Lines** is necessary to allow researchers to include only the **final version** of each claim line when analyzing claims data. **Final Version Flag** has been added to the release data to help to achieve this.

Prior to the release of APCD Data, a Versioning Process is run on each Claims file. The versioning of APCD Claims involves as many steps as necessary to refine as many claim lines as possible into a final version.

Cleaning

There are known issues in the APCD submitted data, which require cleaning in order to properly version APCD claims. Any data items that need to be cleaned are accounted for by claim line, so that we know exactly which lines were altered. **The values are altered for the versioning process only. The data that remains in the Release database will remain as filed by the Payers.** The only flag added to the Release database is the Final Version Flag.

The element used to identify the action applied by the payer is **DC059 – Claim Line Type**. For this element payers can select from a lookup table with five values to define an adjudication action:

DC059 – Claim Line Type	
O	Original
V	Void
R	Replacement
B	Back Out
A	Amendment

Below is a table outlining the cleaning methods applied.

Issue#	**Cleaning Issue**	**Remedy**
1	Some carriers have spelled out **Original** and **Amendment** in the Claim Line Type field **(DC059).**	Any record with a Claim Line Type "**Original**" will be changed to "**O**". Any record with a Claim Line Type "**Amendment**" will be changed to "**A**".
2	Some carriers are sending **negative values** with claim lines coded with Claim Line Types of "**R**" and "**A**" **(DC059).**	The value is changed from **R to V**, and from **empty or A to B** when the charge amount is **negative**.

Resolving Duplicates

The resolution of duplicates is critical in refining claims lines to the final version. Claim lines can be submitted with duplicative data that would result in several claim lines achieving "final version" status when in fact they are a duplicate claim. Below is a table outlining the duplicate claim resolution methodologies applied.

Critical Versioning Fields (Data Elements used to identify duplicates):	
DC001	Payer (OrgID)
DC004	Payer Claim Control Number
DC005	Line Counter
DC005A	Version Number
DC032	CDT Code (procedure code)
DC037	Charge Amount
DC035	Date of Service – From date
DC056	Carrier Specific Unique Member ID
DC059	Claim Line Type (O, V, R, B, A)
DC060	Former Claim Number
Derived by DHCFP	Unique Record ID - assigned by DHCFP to each Claim Line

Issue#	Criteria / Resolution
1	**Duplicate Criteria:** Some organizations are sending duplicate claim lines based on our critical versioning fields: • More than one row exists with **all critical versioning fields matching** except the internal control number Unique Record ID. **Resolution:** Of the group of duplicated claim lines, the row whose **Unique Record ID has the highest number**, is considered the most recently submitted row. The remaining claim lines in the group of duplicate rows are **flagged as Duplicates**. These rows are not considered for the Final Version of the claim line.
2	**Duplicate Criteria:** More than one row exists with **all critical fields matching** except the **Unique Record ID** and the **Version Number**. • The duplicates sometimes had a different version number; this field does not impact our definition of duplicate. **Resolution:** Of the group of duplicated claim lines, the row in which the **Unique Record ID has the highest number**, is considered the most recently submitted row. The remaining claim lines in the group of duplicate rows are flagged as Duplicates. These rows are not considered for the Final Version of the claim line.

Voids and Back Outs

The resolution of **Voids** and **Back Outs** is critical in refining claim lines to the final version, since claim lines can be submitted that are intended to **void or back out a previously submitted claim**. The failure of voids and back outs to capture the claim line intended to be voided or backed out could result in duplicative data that would result in several claim lines achieving "final version" status when in fact they are duplicates. Below is a table outlining the **void and back out claim resolution methodology** applied.

Void and Back Out Methodology
Flag as Voided any claim line that **matches** a **Void** or **Back Out** based on the following fields:

DC001	**Payer (Org ID)**
DC004	**Payer Claim Control Number**
DC056	**Carrier Specific Unique Member ID**
DC032	**CDT Code**
DC035	**Date Of Service From**
DC037	**Charge Amount**

where the **Void** or **Back Out** was processed **after** the **claim** line to be voided or backed out (i.e., the internal **Unique Record ID** is higher).

Replacements and Amendments

The resolution of replacements and amendments is critical in refining claim lines to the final version since claim lines can be submitted that are intended to **replace or amend out a previously submitted claim**. The failure of replacements and amendments to capture the claim line intended could result in duplicative data that would result in several claim lines achieving "final version" status when in fact they are duplicates. Below is a table outlining the **replacement and amendment claim resolution methodology** applied.

Replacement and Amendment Methodology
Flag as Replaced any claim line that **matches** a **Replacement** or **Amendment** based on the following fields:

DC001	**Payer (Org ID)**
DC004	**Payer Claim Control Number**
DC056	**Carrier Specific Unique Member ID**
DC032	**CDT Code**
DC035	**Date Of Service From**
DC037	**Charge Amount**

where the **Replacement** or **Amendment** was processed **after** the claim line to be replaced or amended (i.e., the internal **Unique Record ID** is higher).

Setting the Final Version

The setting of the claim line **Final Version flag** is the last step in the versioning process and is intended to flag the claim line considered the final version based on the results of the previous steps.

The element used to aid with setting **final version** is **DC031 – Claim Status**. This element is a lookup table with eight values that a payer can select from in order to define an adjudication outcome. The values used are from the standard logic applied by the HIPAA Transaction Set.

DC031 – Claim Status Values	
01	Processed as Primary
02	Processed as Secondary
03	Processed as Tertiary (or any later payer)
04	**Denied**
19	Processed as Primary and forwarded to other payer
20	Processed as Secondary and forwarded to other payer
21	Processed as Tertiary and forwarded to other payer
22	**Reversal of previous payment**

The two values above that are highlighted indicate the values that report a **denial** of the line item or the **reversal of payment**.

Final Version Methodology

Set to **Final Version** any **claim line** where:

- **Claim Line Type** is **not Void or Back Out, and**
- Claim is **not flagged as Voided**, **Replaced**, **or Duplicate**
- **Claim Status value is not 04 or 22**

Potential Claim Line Types for **Final Version Flag** are**:**

O	**Original**
R	**Replacement**
A	**Amendment**

Flags used in the Versioning Process are:

- **Final Version Flag**

- **Duplicate Flag**
- **Voided Flag**
- **Replaced Flag**

Only the **Final Version Flag** will be reported in the **APCD Data Release**.

APCD Pharmacy Claim Versioning

Accurate **Versioning** of **APCD Claim Lines** is necessary to allow researchers to include only the **final version** of each claim line when analyzing claims data. **Final Version Flag** has been added to the release data to help to achieve this.

Prior to the release of APCD Data, a Versioning Process is run on each Claims file. The versioning of APCD Claims involves as many steps as necessary to refine as many claim lines as possible into a final version.

Cleaning

There are known issues in the APCD submitted data, which require cleaning in order to properly version APCD claims. Any data items that need to be cleaned are accounted for by claim line, so that we know exactly which lines were altered. **The values are altered for the Versioning Process only. The data that remains in the Release database will remain as filed by the Payers.** The only flag added to the Release Database is the **Final Version Flag**.

The element used to identify the action applied by the payer for Pharmacy Claims is **PC110 – Claim Line Type**. For this element payers can select from a lookup table with five values to define an adjudication action:

PC110 – Claim Line Type	
O	Original
V	Void
R	Replacement
B	Back Out
A	Amendment

Below is a table outlining the cleaning methods applied.

Issue#	**Cleaning Issue**	**Remedy**
1	Some carriers have spelled out **Original** and **Amendment** in the Claim Line Type field **(DC059).**	Any record with a Claim Line Type "**Original**" will be changed to "**O**". Any record with a Claim Line Type "**Amendment**" will be changed to "**A**".
2	Some carriers are sending **negative values** with claim lines coded with Claim Line Types of "**R**" and "**A**" **(PC110).**	The value is changed from **R to V**, and from **empty or A to B** when the charge amount is **negative**.

Resolving Duplicates

The resolution of duplicates is critical in refining claims lines to the final version. Claim lines can be submitted with duplicative data that would result in several claim lines achieving "final version" status when in fact they are a duplicate claim. Below is a table outlining the duplicate claim resolution methodologies applied.

Critical Versioning Fields (Data Elements used to identify duplicates):	
PC001	Org ID
PC004	Payer Claim Control Number
PC005	Line Counter
PC005A	Version Number
PC110	Claim Line Type
PC026	Drug Code
PC035	Charge Amount
PC064	Date Prescription Written
PC107	Carrier Specific Unique Member Id
PC111	Former Claim Number
Derived by DHCFP	Unique Record ID - assigned by DHCFP to each Claim Line

Issue#	Criteria / Resolution
1	**Duplicate Criteria:** Some organizations are sending duplicate claim lines based on our critical versioning fields: • More than one row exists with **all critical versioning fields matching** except the internal control number Unique Record ID. **Resolution:** Of the group of duplicated claim lines, the row whose **Unique Record ID has the highest number**, is considered the most recently submitted row. The remaining claim lines in the group of duplicate rows are **flagged as Duplicates**. These rows are not considered for the Final Version of the claim line.

2	**Duplicate Criteria:** More than one row exists with **all critical fields matching** except the **Unique Record ID** and the **Version Number**. • The duplicates sometimes had a different version number; this field does not impact our definition of duplicate. **Resolution:** Of the group of duplicated claim lines, the row in which the **Unique Record ID has the highest number**, is considered the most recently submitted row. The remaining claim lines in the group of duplicate rows are flagged as Duplicates. These rows are not considered for the Final Version of the claim line.

Voids and Back Outs

The resolution of **Voids** and **Back Outs** is critical in refining claim lines to the final version, since claim lines can be submitted that are intended to **void or back out a previously submitted claim**. The failure of voids and back outs to capture the claim line intended to be voided or backed out could result in duplicative data that would result in several claim lines achieving "final version" status when in fact they are duplicates. Below is a table outlining the **void and back out claim resolution methodology** applied.

Void and Back Out Methodology
Flag as Voided any claim line that **matches** a **Void** or **Back Out** based on the following fields: **PC001** — **Payer (Org ID)** **PC004** — **Payer Claim Control Number** **PC107** — **Carrier Specific Unique Member ID** **PC026** — **Drug Code** **PC064** — **Date Prescription Written** **PC035** — **Charge Amount** where the **Void** or **Back Out** was processed **after** the **claim** line to be voided or backed out (i.e., the internal **Unique Record ID** is higher).

Replacements and Amendments

The resolution of replacements and amendments is critical in refining claim lines to the final version since claim lines can be submitted that are intended to **replace or amend out a previously submitted claim**. The failure of replacements and amendments to capture the claim line intended could result in duplicative data that would result in several claim lines achieving "final version" status when in fact they are duplicates. Below is a table outlining the **replacement and amendment claim resolution methodology** applied.

Replacement and Amendment Methodology
Flag as Replaced any claim line that **matches** a **Replacement** or **Amendment** based on the following fields:

PC001	**Payer (Org ID)**
PC004	**Payer Claim Control Number**
PC107	**Carrier Specific Unique Member ID**
PC026	**Drug Code**
PC064	**Date Prescription Written**
PC035	**Charge Amount**

where the **Replacement** or **Amendment** was processed **after** the claim line to be replaced or amended (i.e., the internal **Unique Record ID** is higher).

Setting the Final Version

The setting of the claim line **Final Version flag** is the last step in the versioning process and is intended to flag the claim line considered the final version based on the results of the previous steps.

The element used to aid with setting **final version** is **PC025 – Claim Status**. This element is a lookup table with eight values that a payer can select from in order to define an adjudication outcome. The values used are from the standard logic applied by the HIPAA Transaction Set.

DC031 – Claim Status Values	
01	Processed as Primary
02	Processed as Secondary
03	Processed as Tertiary (or any later payer)
04	**Denied**
19	Processed as Primary and forwarded to other payer
20	Processed as Secondary and forwarded to other payer
21	Processed as Tertiary and forwarded to other payer
22	**Reversal of previous payment**

The two values above that are highlighted indicate the values that report a **denial** of the line item or the **reversal of payment**.

Final Version Methodology
Set to **Final Version** any **claim line** where: • **Claim Line Type** is **not Void or Back Out, and** • Claim is **not flagged as Voided**, **Replaced**, **or Duplicate** • **Claim Status value is not 04 or 22** **Potential Claim Line Types** for **Final Version Flag** are**:** **O** — **Original** **R** — **Replacement** **A** — **Amendment**

Flags used in the Versioning Process are:

- **Final Version Flag**
- **Duplicate Flag**
- **Voided Flag**
- **Replaced Flag**

Only the **Final Version Flag** will be reported in the **APCD Data Release**.

EDITS

Overview

When Payers deliver APCD data submissions to the Division, an Edits process is run on each submission file to check that the data complies with requirements for each file type and each data element. The file edits perform an important data quality check on incoming submissions from payers. On a data element level, they identify whether or not the information is in the expected format (i.e. alpha vs. numeric), contains invalid characters (i.e. negative values, decimals, future dates) or is missing values (i.e. nulls). If these edits detect any issues with a file, they are identified on a report that is sent to the payer.

Data type errors such as incorrect date formats, decimals, etc. will fail a file automatically and it must be corrected and resubmitted. Failure to meet an expected threshold may also result in a resubmission.

Edit Levels

Data elements are grouped into four categories (A, B, C, Z) which indicate their relative analytic value to the Division. Refer to the **File Layout** section of this document to view the Edit Level for each Data Element.

'**A**' level fields must meet their **APCD threshold percentage** in order for a file to pass, and there is an allowance for up to a 2% variance within the error margin percentage (depending on the data element). If any '**A**' level field falls below this percentage it will result in a failed file submission for the payer and a discussion with their liaison regarding corrective action. The other categories (**B, C, Z**) are also **monitored** but no further action is required at this time.

Historical Claims Data Edit Levels Relaxed

Beginning July 1, 2010, edits have been enforced on Claims data (with approved variances). For historical Claims files submitted by the payers (2008/2009/Jan-Jun 2010), edits were relaxed. The quality of data for older years does not contain the same level of completeness (in some cases). Edits were run on historical claims and results were reported to Payers, but the weight was removed from some of the edits. Many payers have since implemented new systems, made a concerted effort to improve data quality and worked with the Division to provide more comprehensive data.

Table of Edits

File Type	Element	Element Name	Element Description	Edit ID	Message
HD	HD002	Payer	Payer submitting payments/Council Submitter Code	209	The Payer Field on the Header Record must be a valid DHCFP assigned OrgID and must be a valid filer for the given filing type.
HD	HD004	Type of File	Type of File	216	The header field HD004 (Type of File) does not match the file type on the Transmittal Sheet.
HD	HD004	Type of File	Type of File	3896	Partial Replacement submissions are not allowed. Please resubmit with the Full Replacement indicator.
HD	HD004	Type of File	Type of File	3897	The file type is not valid for the submission period selected.
HD	HD005	Period Beginning Date	CCYYMM	204	The Period Beginning Date on the Header Record must correspond with the Year and Quarter/Month entered on the Transmittal Sheet.
HD	HD006	Period Ending Date	CCYYMM	205	The Period End Date on the Header Record must correspond with the Year and Quarter/Month entered on the Transmittal Sheet.
HD	HD007	Record Count	Total number of records submitted in this file	218	The Record count in the Header Record (HD007) must match the Record Count entered on the transmittal.

File Type	Element	Element Name	Element Description	Edit ID	Message
HD	HD007	Record Count	Total number of records submitted in this file	206	The Record Count in the Header Record must match the number of records in the file.
DC	DC001	Payer	Payer submitting payments; Council Submitter Code	1943	The Payer Field within each record of the file must match the Payer Field on the Header Record.
DC	DC001	Payer	Payer submitting payments; Council Submitter Code	2321	Payer is required.
DC	DC002	National Plan ID	CMS National Plan ID	3644	National Plan ID field must match the National Plan ID on the Header Record
DC	DC003	Dental Insurance Type Code/PR	Dental Insurance Type Code/PR	1992	Dental Insurance Type Code/PR must be within the valid domain of values.
DC	DC003	Dental Insurance Type Code/PR	Dental Insurance Type Code/PR	2323	Dental Insurance Type Code/PR is required.
DC	DC004	Payer Claim Control Number	Must apply to entire claim and be unique within the payers system	2324	Payer Claim Control Number is required.
DC	DC005	Line Counter	Line number for this service	2325	Line Counter is required.
DC	DC005	Line Counter	Line number for this service	2649	Line Counter must be in integer (no decimal points) format, cannot be zero and cannot be negative.
DC	DC005A	Version Number	Claim Service Line Version Number.	2326	Version Number is required.
DC	DC005A	Version Number	Claim Service Line Version Number.	2650	Version Number must be in integer (no decimal points) format and cannot be negative.
DC	DC006	Insured Group or Policy Number	Used to create unique member ID, for internal validation and data quality; not released.	2327	Insured Group or Policy Number is required.
DC	DC007	Subscriber SSN	Used to create unique member ID, for internal validation and data quality; not released.	2328	Subscriber SSN is required.
DC	DC007	Subscriber SSN	Used to create unique member ID, for internal validation and data quality; not released.	3732	Subscriber SSN must be 9 digits, numeric and in valid format.
DC	DC008	Plan Specific Contract Number	Used to create unique member ID, for internal validation and data quality; not released.	2329	Plan Specific Contract Number is required.
DC	DC009	Member Suffix or Sequence Number	Used to create unique member ID, for internal validation and data quality; not released.	2330	Member Suffix or Sequence Number is required.
DC	DC010	Member Identification Code	Used to create unique member ID, for internal validation and data quality; not released.	2331	Member Identification Code is required.
DC	DC010	Member Identification Code	Used to create unique member ID, for internal validation and data quality; not released.	3735	MemberIdentificationCode must be 9 digits, numeric and in valid format.

File Type	Element	Element Name	Element Description	Edit ID	Message
DC	DC010	Member Identification Code	Used to create unique member ID, for internal validation and data quality; not released.	3898	Member Identification Code must be in integer (no decimal points) format, cannot be zero and cannot be negative.
DC	DC011	Individual Relationship Code	Members relationship to subscriber:	1993	Individual Relationship Code must be within the valid domain of values.
DC	DC011	Individual Relationship Code	Members relationship to subscriber:	2332	Individual Relationship Code is required.
DC	DC011	Individual Relationship Code	Members relationship to subscriber:	2651	Individual Relationship Code must be in integer (no decimal points) format .
DC	DC012	Member Gender	Member Gender	2333	Member Gender is required.
DC	DC012	Member Gender	Member Gender	2731	Member Gender must be within the valid domain of values.
DC	DC013	Member Date of Birth	YYYYMMDD	3753	Member Date of Birth cannot be after the service date.
DC	DC013	Member Date of Birth	YYYYMMDD	2578	Member Date of Birth must be in date format (YYYYMMDD) and cannot be a future date and cannot be a future date.
DC	DC013	Member Date of Birth	YYYYMMDD	2334	Member Date of Birth is required.
DC	DC014	Member City Name	City name of member	2335	Member City Name is required.
DC	DC015	Member State or Province	Member State or Province	2336	Member State or Province is required.
DC	DC016	Member ZIP Code	Member ZIP Code	2337	Member ZIP Code is required.
DC	DC016	Member ZIP Code	Member ZIP Code	3646	Member zip code must be within the valid domain of values.
DC	DC017	Date Service Approved (AP Date)	YYYYMMDD (Generally the same as the paid date)	2338	Date Service Approved (AP Date) is required.
DC	DC017	Date Service Approved (AP Date)	YYYYMMDD (Generally the same as the paid date)	2579	Date Service Approved (AP Date) must be in date format (YYYYMMDD) and cannot be a future date.
DC	DC018	Service PV Number	Payer assigned PV number	2339	Service PV Number is required.
DC	DC019	Service PV Tax ID Number	Federal taxpayers identification number	2340	Service PV Tax ID Number is required.
DC	DC019	Service PV Tax ID Number	Federal taxpayers identification number	3648	Service PV Tax ID must be in valid Tax ID format
DC	DC019	Service PV Tax ID Number	Federal taxpayers identification number	3899	Service PV Tax ID Number must be in integer (no decimal points) format, cannot be zero and cannot be negative.

File Type	Element	Element Name	Element Description	Edit ID	Message
DC	DC020	National Service PV ID	See https://nppes.cms.hhs.gov/NPPES/NPIRegistryHome.do for PV lookup resource	3649	National Service PV ID must be 10 digits
DC	DC020	National Service PV ID	See https://nppes.cms.hhs.gov/NPPES/NPIRegistryHome.do for PV lookup resource	3754	NationalPVID must be in integer (no decimal points) format.
DC	DC020	National Service PV ID	See https://nppes.cms.hhs.gov/NPPES/NPIRegistryHome.do for PV lookup resource	2341	National Service PV ID is required.
DC	DC021	Service PV Entity Type Qualifier	HIPAA PV taxonomy	2342	Service PV Entity Type Qualifier is required.
DC	DC021	Service PV Entity Type Qualifier	HIPAA PV taxonomy	2652	Service PV Entity Type Qualifier must be in integer (no decimal points) format .
DC	DC021	Service PV Entity Type Qualifier	HIPAA PV taxonomy	1996	Service PV Entity Type Qualifier must be within the valid domain of values.
DC	DC022	Service PV First Name	Service PV First Name	3894	Service PV First Name is required when Service PV Entity Type Qualifier (DC021) equals 1.
DC	DC023	Service PV Middle Name	Service PV Middle Name	3895	Service PV Middle Name is required when Service PV Entity Type Qualifier (DC021) equals 1.
DC	DC024	Service PV Last Name or Organization Name	Service PV Last Name or Organization Name	2345	Service PV Last Name or Organization Name is required.
DC	DC025	Delegated Benefit Administrator Organization ID	If the record is sourced from a delegated benefit administrator, this field contains the DHCFP assigned organization ID for the delegated benefit administrator. Contact DHCFP for the appropriate value. Report null values if not applicable.	3863	When present, the DelegatedBenefitAdministratorOrganizationID must be a valid orgid.
DC	DC025	Delegated Benefit Administrator Organization ID	If the record is sourced from a delegated benefit administrator, this field contains the DHCFP assigned organization ID for the delegated benefit administrator. Contact DHCFP for the appropriate value. Report null values if not applicable.	3913	Delegated Benefit Administrator Organization ID must be in integer (no decimal points) format.
DC	DC026	Service PV Specialty	As defined by payer. Dictionary for specialty code values must be supplied during testing.	3864	Service PV Specialty must be within the valid domain of values.
DC	DC026	Service PV Specialty	As defined by payer. Dictionary for specialty code values must be supplied during testing.	2347	Service PV Specialty is required.
DC	DC027	Service PV City Name	Practice location	2348	Service PV City Name is required.

File Type	Element	Element Name	Element Description	Edit ID	Message
DC	DC028	Service PV State	Service PV State	2349	Service PV State is required.
DC	DC028	Service PV State	Service PV State	3825	Service PV State must be within the valid domain of values.
DC	DC029	Service PV ZIP Code	Service PV ZIP Code	3826	Service PV Zip Code must be within the valid domain of values.
DC	DC029	Service PV ZIP Code	Service PV ZIP Code	2350	Service PV ZIP Code is required.
DC	DC030	Facility Type - Professional	Facility Type - Professional	2351	Facility Type - Professional is required.
DC	DC030	Facility Type - Professional	Facility Type - Professional	3827	Facility Type must be within the valid domain of values.
DC	DC031	Claim Status	Claim Status	1998	Claim Status must be within the valid domain of values.
DC	DC031	Claim Status	Claim Status	2352	Claim Status is required.
DC	DC031	Claim Status	Claim Status	2653	Claim Status must be in integer (no decimal points) format .
DC	DC032	CDT Code	Common Dental Terminology code	2353	CDT Code is required.
DC	DC032	CDT Code	Common Dental Terminology code	1999	CDT Code must be within the valid domain of values.
DC	DC033	Procedure Modifier - 1	Procedure Modifier - 1	2000	Procedure Modifier - 1 must be within the valid domain of values.
DC	DC034	Procedure Modifier - 2	Procedure Modifier - 2	2001	Procedure Modifier - 2 must be within the valid domain of values.
DC	DC035	Date of Service - From	First date of service for this service line. YYYYMMDD	3652	Date of Service - From may not be future date
DC	DC035	Date of Service - From	First date of service for this service line. YYYYMMDD	2356	Date of Service - From is required.
DC	DC035	Date of Service - From	First date of service for this service line. YYYYMMDD	2580	Date of Service - From must be in date format (YYYYMMDD) and cannot be a future date.
DC	DC036	Date of Service - Thru	Last date of service for this service line. YYYYMMDD	2581	Date of Service - Thru must be in date format (YYYYMMDD) and cannot be a future date.
DC	DC036	Date of Service - Thru	Last date of service for this service line. YYYYMMDD	3653	Date of Service - Thru must be >= Date of Service - From
DC	DC037	Charge Amount	Charge Amount	2654	Charge Amount must be in integer (no decimal points) format cannot be zero and cannot be negative.
DC	DC037	Charge Amount	Charge Amount	2358	Charge Amount is required.
DC	DC038	Paid Amount	Paid Amount	2655	Paid Amount must be in integer (no decimal points) format and cannot be negative
DC	DC038	Paid Amount	Paid Amount	3757	Paid amount must be present when claim status = 01, 02, 03, 19, 20, 21.

File Type	Element	Element Name	Element Description	Edit ID	Message
DC	DC039	Copay Amount	The preset, fixed dollar amount for which the individual is responsible Do not code decimal point. Decimal points are implied.	2360	Copay Amount is required.
DC	DC039	Copay Amount	The preset, fixed dollar amount for which the individual is responsible Do not code decimal point. Decimal points are implied.	2656	Copay Amount must be in integer (no decimal points) format and cannot be negative.
DC	DC040	Coinsurance Amount	The dollar amount an individual is responsible for – not the percentage. Do not code decimal point.	2361	Coinsurance Amount is required.
DC	DC040	Coinsurance Amount	The dollar amount an individual is responsible for – not the percentage. Do not code decimal point.	2657	Coinsurance Amount must be in integer (no decimal points) format and cannot be negative.
DC	DC041	Deductible Amount	Deductible Amount	2362	Deductible Amount is required.
DC	DC041	Deductible Amount	Deductible Amount	2658	Deductible Amount must be in integer (no decimal points) format and cannot be negative.
DC	DC042	PR ID Number	Must correspond to the PR file	2363	PR ID Number is required.
DC	DC043	Member Street Address	Used to create unique member ID, for internal validation and data quality; not released.	2364	Member Street Address is required.
DC	DC044	Billing PV Tax ID Number	Billing PV Tax ID Number	2365	Billing PV Tax ID Number is required.
DC	DC044	Billing PV Tax ID Number	Billing PV Tax ID Number	3654	Billing PV Tax ID Number must be in valid Tax ID format
DC	DC044	Billing PV Tax ID Number	Billing PV Tax ID Number	3900	Billing PV Tax ID Number must be in integer (no decimal points) format, cannot be zero and cannot be negative.
DC	DC045	Paid Date	YYYYMMDD	3647	Paid must be between the Period Begin and Period End Dates on the Transmittal Record.
DC	DC045	Paid Date	YYYYMMDD	2366	Paid Date is required.
DC	DC045	Paid Date	YYYYMMDD	2582	Paid Date must be in date format (YYYYMMDD) and cannot be a future date.
DC	DC046	Allowed Amount	Allowed Amount	2367	Allowed Amount is required when Claim Status (DC031) = 04 or 22.
DC	DC046	Allowed Amount	Allowed Amount	2659	Allowed Amount must be in integer (no decimal points) format cannot be negative and cannot be zero.
DC	DC047	Tooth Number/Letter	provides further detail on procedure	3828	Tooth Number/Letter must be within the valid domain of values.
DC	DC048	Dental Quadrant	provides further detail on procedure	3830	Dental Quadrant must be within the valid domain of values.
DC	DC049	Tooth Surface	provides further detail on procedure	3829	Tooth Surface must be within the valid domain of values.

File Type	Element	Element Name	Element Description	Edit ID	Message
DC	DC050	Subscriber Last Name	Used to create unique member ID, for internal validation and data quality; not released.	2371	Subscriber Last Name is required.
DC	DC051	Subscriber First Name	Used to create unique member ID, for internal validation and data quality; not released.	2372	Subscriber First Name is required.
DC	DC053	Member Last Name	Used to create unique member ID, for internal validation and data quality; not released.	2374	Member Last Name is required.
DC	DC054	Member First Name	Used to create unique member ID, for internal validation and data quality; not released.	2375	Member First Name is required.
DC	DC055	Member Middle Initial	Used to create unique member ID, for internal validation and data quality; not released.	2376	Member Middle Initial is required.
DC	DC056	Carrier Specific Unique Member ID	This is the number the carrier uses internally to uniquely identify the member.	2377	Carrier Specific Unique Member ID is required.
DC	DC057	Carrier Specific Unique Subscriber ID	This is the number the carrier uses internally to uniquely identify the subscriber.	2378	Carrier Specific Unique Subscriber ID is required.
DC	DC058	Member Address 2	Address of member, which may include apartment number or suite, or other secondary information besides the street.	3813	The Member Address 2 is required when the Member Street Address (DC043) is not present.
DC	DC059	Claim Line Type	Code indicating type of record.	2733	Claim Line Type must be within the valid domain of values.
DC	DC059	Claim Line Type	Code indicating type of record.	2380	Claim Line Type is required.
DC	DC060	Former Claim Number	If this is not an original claim (Claim line type = "O", then the previous claim number that this is replacing/voiding.	3856	The Former Claim Number is required when Claim Line Type (MC059) = V, R, B, or A.
DC	DC899	Record Type	DC	3725	RecordType must match the RecordType in the header and the trailer.
DC	DC899	Record Type	DC	2382	Record Type is required.
MC	MC001	Payer	Payer submitting payments, Council Submitter Code	1942	The Payer Field within each record of the file must match the Payer Field on the Header Record.
MC	MC001	Payer	Payer submitting payments, Council Submitter Code	2089	Payer is required.
MC	MC002	National Plan ID	CMS National Plan ID	3656	The National Plan ID within each record of the file must match the National Plan ID on the Header Record.
MC	MC003	Insurance Type Code/PR	See tlkpClaimInsuranceType	1958	Insurance Type Code/PR must be within the valid domain of values.
MC	MC003	Insurance Type Code/PR	See tlkpClaimInsuranceType	2091	Insurance Type Code/PR is required.

File Type	Element	Element Name	Element Description	Edit ID	Message
MC	MC004	Payer Claim Control Number	Must apply to the entire claim and be unique within the payer's system	2092	Payer Claim Control Number is required.
MC	MC005	Line Counter	Line number for this service, The line counter begins with 1 and is incremented by 1 for each additional service line of a claim	2093	Line Counter is required.
MC	MC005	Line Counter	Line number for this service, The line counter begins with 1 and is incremented by 1 for each additional service line of a claim	2599	Line Counter must be in integer (no decimal points) format cannot be negative and cannot be zero.
MC	MC005A	Version Number	Version number of this claim service line, The version number begins with 0 and is incremented by 1 for each subsequent version of that service line	2094	Version Number is required.
MC	MC005A	Version Number	Version number of this claim service line, The version number begins with 0 and is incremented by 1 for each subsequent version of that service line	2600	Version Number must be in integer (no decimal points) format and cannot be negative.
MC	MC006	Insured Group or Policy Number	Group or policy number (not the number that uniquely identifies the subscriber)	2095	Insured Group or Policy Number is required.
MC	MC007	Subscriber SSN	Subscriber SSN, Set as null if unavailable	2096	Subscriber SSN is required.
MC	MC007	Subscriber SSN	Subscriber SSN, Set as null if unavailable	3729	Subscriber SSN must be 9 digits, numeric and in valid format.
MC	MC007	Subscriber SSN	Subscriber SSN, Set as null if unavailable	3901	Subscriber SSN must be in integer (no decimal points) format, cannot be zero and cannot be negative.
MC	MC008	Plan Specific Contract Number	Encrypted plan assigned Set as null if contract number = subscriber’s social security number	2097	Plan Specific Contract Number is required.
MC	MC009	Member Suffix or Sequence Number	Uniquely numbers the member within the contract	2098	Member Suffix or Sequence Number is required.
MC	MC010	Member SSN	Members social security number (set as null if unavailable)	2099	Member SSN is required.
MC	MC010	Member SSN	Members social security number (set as null if unavailable)	3728	Member SSN must be 9 digits, numeric and in valid format.
MC	MC010	Member SSN	Members social security number (set as null if unavailable)	3902	Member SSN must be in integer (no decimal points) format, cannot be zero and cannot be negative.
MC	MC011	Individual Relationship Code	Member's relationship to subscriber as in tlkpClaimIndividualRelationship	1959	Individual Relationship Code must be within the valid domain of values.
MC	MC011	Individual Relationship Code	Member's relationship to subscriber as in tlkpClaimIndividualRelationship	2100	Individual Relationship Code is required.
MC	MC011	Individual Relationship Code	Member's relationship to subscriber as in tlkpClaimIndividualRelationship	2601	Individual Relationship Code must be in integer (no decimal points) format .

File Type	Element	Element Name	Element Description	Edit ID	Message
MC	MC012	Member Gender	M - Male, F - Female, U - Unknown	2101	Member Gender is required.
MC	MC012	Member Gender	M - Male, F - Female, U - Unknown	1960	Member Gender must be within the valid domain of values.
MC	MC013	Member Date of Birth	CCYYMMDD	2565	Member Date of Birth must be in date format (YYYYMMDD) and cannot be a future date.
MC	MC013	Member Date of Birth	CCYYMMDD	2102	Member Date of Birth is required.
MC	MC013	Member Date of Birth	CCYYMMDD	3848	The Member Date of Birth cannot be after the date of service.
MC	MC014	Member City Name	City name of member	2103	Member City Name is required.
MC	MC015	Member State or Province	As defined by the US Postal Service	2104	Member State or Province is required.
MC	MC015	Member State or Province	As defined by the US Postal Service	3759	Member State or Province must be within the valid domain of values.
MC	MC016	Member ZIP Code	ZIP Code of member - may include non-US codes	3657	Member zip code must be within the valid domain of values.
MC	MC016	Member ZIP Code	ZIP Code of member - may include non-US codes	2105	Member ZIP Code is required.
MC	MC017	Date Service Approved (AP Date)	CCYYMMDD, (Generally the same as the paid date)	2106	Date Service Approved (AP Date) is required.
MC	MC017	Date Service Approved (AP Date)	CCYYMMDD, (Generally the same as the paid date)	2566	Date Service Approved (AP Date) must be in date format (YYYYMMDD) and cannot be a future date.
MC	MC018	Admission Date	Required for all inpatient claims, CCYYMMDD	2567	Admission Date must be in date format (YYYYMMDD) and cannot be a future date.
MC	MC018	Admission Date	Required for all inpatient claims, CCYYMMDD	3760	Admission Date is required when Type of Bill on Facility Claims (MC036) = 011x, 018x, 021x, 028x, 041x, 065x, 066x, 084x, 086x ,089x or Type of Claim = 002, must be in CCYYMMDD format and cannot be greater than the Discharge Date (MC069).
MC	MC019	Admission Hour	Required for all inpatient claims, Time is expressed in military time – HH or HHMM	3761	Admission Hour is required when Type of Bill on Facility Claims (MC036) = 011x, 018x, 021x, 028x, 041x, 065x, 066x, 084x, 086x, 089x and Type of Claim = 002, must be in HHMM format.
MC	MC019	Admission Hour	Required for all inpatient claims, Time is expressed in military time – HH or HHMM	2602	Admission Hour must be in integer (no decimal points) format and cannot be negative.
MC	MC020	Admission Type	See tlkpAdmissionType	2603	Admission Type must be in integer (no decimal points) format .
MC	MC020	Admission Type	See tlkpAdmissionType	3744	Admission Type must be within the valid domain of values.

File Type	Element	Element Name	Element Description	Edit ID	Message
MC	MC020	Admission Type	See tlkpAdmissionType	3771	The Admission Type is required when Type of Bill on Facility Claims equals 011x, 018x, 021x, 028x, 041x, 065x, 066x, 084x, 086x, or 089x and Type of Claim = 002.
MC	MC021	Admission Source	See tlkpAdmissionSource	3772	The Admission Source is required when Type of Bill on Facility Claims equals 011x, 018x, 021x, 028x, 041x, 065x, 066x, 084x, 086x, or 089x and Type of Claim = 002.
MC	MC021	Admission Source	See tlkpAdmissionSource	3745	Admission Source must be within the valid domain of values.
MC	MC022	Discharge Hour	Hour in military time – HH or HHMM	3762	Discharge Hour is required when Type of Bill on Facility Claims (MC036) = 011x, 018x, 028x, 041x, 065x, 066x, 084x, 086x, 089x and Type of Claim = 002, must be in HHMM format, cannot have an hour greater than 23 and must be greater than the admission hour (MC019) when the Admission Date (MC018) and the Discharge date (MC069) are equal.
MC	MC022	Discharge Hour	Hour in military time – HH or HHMM	2604	Discharge Hour must be in integer (no decimal points) format and cannot be negative.
MC	MC023	Discharge Status	See tlkpDischargeStatus	3737	DischargeStatus must be within the valid domain of values.
MC	MC023	Discharge Status	See tlkpDischargeStatus	2605	Discharge Status must be in integer (no decimal points) format .
MC	MC023	Discharge Status	See tlkpDischargeStatus	3849	The Discharge Status is required when Type of Bill on Facility Claims equals 011x, 018x, 021x, 028x, 041x, 065x, 066x, 084x, 086x, or 089x and Type of Claim (MC094) = 002.
MC	MC024	Service PV Number	Payer assigned PV number	2113	Service PV Number is required.
MC	MC025	Service PV Tax ID Number	Federal taxpayer's identification number	2114	Service PV Tax ID Number is required.
MC	MC025	Service PV Tax ID Number	Federal taxpayer's identification number	3763	Service PV Tax ID must be numeric and 9 digits.
MC	MC026	National Service PV ID	Required if National PV ID is mandated, for use under HIPAA	3659	National Service PV ID must be numeric and 10 digits.
MC	MC026	National Service PV ID	Required if National PV ID is mandated, for use under HIPAA	2115	National Service PV ID is required.
MC	MC027	Service PV Entity Type Qualifier	1 Person, 2 Non-Person Entity, HIPAA PV taxonomy classifies PV groups (clinicians who bill as a group practice or under a corporate name, even if that group is composed of one PV)	2116	Service PV Entity Type Qualifier is required.
MC	MC027	Service PV Entity Type Qualifier	1 Person, 2 Non-Person Entity, HIPAA PV taxonomy classifies PV groups (clinicians who bill as a group practice or under a corporate name, even if that group is composed of one PV)	2606	Service PV Entity Type Qualifier must be in integer (no decimal points) format .

File Type	Element	Element Name	Element Description	Edit ID	Message
MC	MC027	Service PV Entity Type Qualifier	1 Person, 2 Non-Person Entity, HIPAA PV taxonomy classifies PV groups (clinicians who bill as a group practice or under a corporate name, even if that group is composed of one PV)	1964	Service PV Entity Type Qualifier must be within the valid domain of values.
MC	MC028	Service PV First Name	Individual first name, Set to null if PV is a facility or organization	3891	Service PV First name is required when Service PV Entity Type Qualifier (MC027) = 1.
MC	MC029	Service PV Middle Name	Individual middle name or initial, Set to null if PV is a facility or organization	3892	The Service PV Middle Name is required when Service PV Entity Type Qualifier (MC027) = 1.
MC	MC030	Service PV Last Name or Organization Name	Full name of PV organization, or last name of individual PV	2119	Service PV Last Name or Organization Name is required.
MC	MC031	Service PV Suffix	Suffix to individual name, Set to null if PV is a facility or organization., Should be used to capture the generation of the individual clinician (e.g., Jr. Sr., III), if applicable, rather than	3893	The Service PV Suffix is required when Service PV Entity Type Qualifier (MC027) = 1.
MC	MC031	Service PV Suffix	Suffix to individual name, Set to null if PV is a facility or organization., Should be used to capture the generation of the individual clinician (e.g., Jr. Sr., III), if applicable, rather than	2700	Service PV Suffix must be within the valid domain of values.
MC	MC032	Service PV Specialty	As defined by payer, Dictionary for specialty code values, must be supplied during testing	3850	The Service PV Specialty must be within the valid domain of values.
MC	MC032	Service PV Specialty	As defined by payer, Dictionary for specialty code values, must be supplied during testing	2121	Service PV Specialty is required.
MC	MC033	Service PV City Name	City name of PV - preferably practice location	2122	Service PV City Name is required.
MC	MC034	Service PV State	As defined by the US Postal Service	2123	Service PV State is required.
MC	MC034	Service PV State	As defined by the US Postal Service	3851	The Service PV State must be within the valid domain of values.
MC	MC035	Service PV ZIP Code	ZIP Code of PV - may include non-US codes Do not include dash	3852	The Service PV Zip Code must be within the valid domain of values.
MC	MC035	Service PV ZIP Code	ZIP Code of PV - may include non-US codes Do not include dash	2124	Service PV ZIP Code is required.
MC	MC036	Type of Bill – on Facility Claims	See tlkpTypeOfBillBillClassification and tlkpTypeOfBillFacilityType	2607	Type of Bill – on Facility Claims must be in integer (no decimal points) format .
MC	MC036	Type of Bill – on Facility Claims	See tlkpTypeOfBillBillClassification and tlkpTypeOfBillFacilityType	3741	TypeofBillBillClassification must be within the valid domain of values.
MC	MC036	Type of Bill – on Facility Claims	See tlkpTypeOfBillBillClassification and tlkpTypeOfBillFacilityType	3742	TypeofBillFacilityType must be within the valid domain of values.

File Type	Element	Element Name	Element Description	Edit ID	Message
MC	MC036	Type of Bill – on Facility Claims	See tlkpTypeOfBillBillClassification and tlkpTypeOfBillFacilityType	3773	The Type of Bill on Facility Claims is required when Type of Claim (MC094) = 002.
MC	MC037	Site of Service – on NSF/CMS 1500 Claims	See tlkpSiteOfService	3774	The Site of Service on NSF CMS 1500 Claims is required when Type of Claim (MC094) = 001.
MC	MC037	Site of Service – on NSF/CMS 1500 Claims	See tlkpSiteOfService	3740	Site of service must be within the valid domain of values.
MC	MC038	Claim Status	See tlkpClaimStatus	1969	Claim Status must be within the valid domain of values.
MC	MC038	Claim Status	See tlkpClaimStatus	2127	Claim Status is required.
MC	MC038	Claim Status	See tlkpClaimStatus	2608	Claim Status must be in integer (no decimal points) format .
MC	MC039	Admitting Diagnosis	Required on all inpatient admission claims and encounters ICD-9-CM Do not code decimal point	3746	Admitting Diagnosis must be within the valid domain of values.
MC	MC039	Admitting Diagnosis	Required on all inpatient admission claims and encounters ICD-9-CM Do not code decimal point	3775	The Admitting Diagnosis is required when Type of Claim (MC094) = 002 and Type of Bill on Facility Claims (MC036) = 011x, 018x, 021x, 028x, 041x, 065x, 066x, 084x, 086x or 089x.
MC	MC040	E-Code	Describes an injury, poisoning or adverse effect ICD-9-CM Do not include decimal	1971	E-Code must be within the valid domain of values.
MC	MC041	Principal Diagnosis	ICD-9-CM Do not code decimal point. This should be the principal diagnosis given on the claim header.	1972	Principal Diagnosis must be within the valid domain of values.
MC	MC041	Principal Diagnosis	ICD-9-CM Do not code decimal point. This should be the principal diagnosis given on the claim header.	2130	Principal Diagnosis is required.
MC	MC042	Other Diagnosis – 1	ICD-9-CM Do not code decimal point	2714	Other Diagnosis – 1 must be within the valid domain of values.
MC	MC043	Other Diagnosis – 2	ICD-9-CM Do not code decimal point	2715	Other Diagnosis – 2 must be within the valid domain of values.
MC	MC044	Other Diagnosis – 3	ICD-9-CM Do not code decimal point	2716	Other Diagnosis – 3 must be within the valid domain of values.
MC	MC045	Other Diagnosis – 4	ICD-9-CM Do not code decimal point	2717	Other Diagnosis – 4 must be within the valid domain of values.
MC	MC046	Other Diagnosis – 5	ICD-9-CM Do not code decimal point	2718	Other Diagnosis – 5 must be within the valid domain of values.
MC	MC047	Other Diagnosis – 6	ICD-9-CM Do not code decimal point	2719	Other Diagnosis – 6 must be within the valid domain of values.
MC	MC048	Other Diagnosis – 7	ICD-9-CM Do not code decimal point	2720	Other Diagnosis – 7 must be within the valid domain of values.
MC	MC049	Other Diagnosis – 8	ICD-9-CM Do not code decimal point	2721	Other Diagnosis – 8 must be within the valid domain of values.
MC	MC050	Other Diagnosis – 9	ICD-9-CM Do not code decimal point	2722	Other Diagnosis – 9 must be within the valid domain of values.
MC	MC051	Other Diagnosis – 10	ICD-9-CM Do not code decimal point	2723	Other Diagnosis – 10 must be within the valid domain of values.
MC	MC052	Other Diagnosis – 11	ICD-9-CM Do not code decimal point	2724	Other Diagnosis – 11 must be within the valid domain of values.

File Type	Element	Element Name	Element Description	Edit ID	Message
MC	MC053	Other Diagnosis – 12	ICD-9-CM Do not code decimal point	2725	Other Diagnosis – 12 must be within the valid domain of values.
MC	MC054	Revenue Code	National Uniform Billing Committee Codes Code using leading zeroes, left-justified, and four digits.	1973	Revenue Code must be within the valid domain of values.
MC	MC054	Revenue Code	National Uniform Billing Committee Codes Code using leading zeroes, left-justified, and four digits.	3777	The Revenue Code is required when Type of Claim (MC094) = 002.
MC	MC055	Procedure Code	Health Care Common Procedural Coding System (HCPCS). This includes the CPT codes of the American Medical Association.	1974	Procedure Code must be within the valid domain of values.
MC	MC056	Procedure Modifier - 1	Procedure modifier required when a modifier clarifies/improves the reporting accuracy of the associated procedure code	1975	Procedure Modifier - 1 must be within the valid domain of values.
MC	MC057	Procedure Modifier - 2	Procedure modifier required when a modifier clarifies/improves the reporting accuracy of the associated procedure code	1976	Procedure Modifier - 2 must be within the valid domain of values.
MC	MC058	ICD9-CM Procedure Code	Primary ICD9-CM code given on the claim header. Do not code decimal point	1977	ICD9-CM Procedure Code must be within the valid domain of values.
MC	MC058	ICD9-CM Procedure Code	Primary ICD9-CM code given on the claim header. Do not code decimal point	3779	The ICD9-CM Procedure Code is required when Type of Bill on Facility Claims equals 011x, 018x, 021x, 028x, 041x, 065x, 066x, 084x, 086x, or 089x.
MC	MC059	Date of Service – From	First date of service for this service line CCYYMMDD	3662	Date of Service - From may not be future date
MC	MC059	Date of Service – From	First date of service for this service line CCYYMMDD	2148	Date of Service – From is required.
MC	MC059	Date of Service – From	First date of service for this service line CCYYMMDD	2568	Date of Service – From must be in date format (YYYYMMDD) and cannot be a future date.
MC	MC060	Date of Service – To	Last date of service for this service line CCYYMMDD	2149	Date of Service – To is required.
MC	MC060	Date of Service – To	Last date of service for this service line CCYYMMDD	3663	Date of Service - Thru may not be future date
MC	MC060	Date of Service – To	Last date of service for this service line CCYYMMDD	2569	Date of Service – To must be in date format (YYYYMMDD) and cannot be a future date.
MC	MC061	Quantity	Count of services performed. Should be set equal to 1 on all Observation bed service lines, for consistency.	2609	Quantity must be in integer (no decimal points) format and cannot be negative.
MC	MC061	Quantity	Count of services performed. Should be set equal to 1 on all Observation bed service lines, for consistency.	3780	The Quantity is required when Site of Service on NSF CMS 1500 claims is populated or when Type of Bill on Facility Claims equals 012x, 013x, 014x, 022x, 023x, 032x, 033x, 034x, 043x, 071x, 072x, 073x, 074x, 075x, 076x, 079x, 081x, 082x, 083x, or 085x.
MC	MC062	Charge Amount	Do not code decimal point	2151	Charge Amount is required.

File Type	Element	Element Name	Element Description	Edit ID	Message
MC	MC062	Charge Amount	Do not code decimal point	2610	Charge Amount must be in integer (no decimal points) format and cannot be zero.
MC	MC063	Paid Amount	Includes any withhold amounts. Do not code decimal point.	2611	Paid Amount must be in integer (no decimal points) format and cannot be negative.
MC	MC063	Paid Amount	Includes any withhold amounts. Do not code decimal point.	3781	The Paid Amount is required when Claim Status (MC038) = 01,02,03,19,20, 21.
MC	MC064	Prepaid Amount	For capitated services, the fee for service equivalent amount. Do not include decimal point.	2153	Prepaid Amount is required.
MC	MC064	Prepaid Amount	For capitated services, the fee for service equivalent amount. Do not include decimal point.	2612	Prepaid Amount must be in integer (no decimal points) format and cannot be zero.
MC	MC065	Copay Amount	The preset, fixed dollar amount for which the individual is responsible Do not code decimal point	2154	Copay Amount is required.
MC	MC065	Copay Amount	The preset, fixed dollar amount for which the individual is responsible Do not code decimal point	2613	Copay Amount must be in integer (no decimal points) format and cannot be negative.
MC	MC066	Coinsurance Amount	Do not code decimal point	2155	Coinsurance Amount is required.
MC	MC066	Coinsurance Amount	Do not code decimal point	2614	Coinsurance Amount must be in integer (no decimal points) format and cannot be negative.
MC	MC067	Deductible Amount	Do not code decimal point	2156	Deductible Amount is required.
MC	MC067	Deductible Amount	Do not code decimal point	2615	Deductible Amount must be in integer (no decimal points) format and cannot be negative.
MC	MC068	Patient Control Number	Number assigned by hospital	3782	The Patient Control Number is required when Claim Status (MC094) equals 001 or 002 and Site of Service On NSF CMS 1500 Claims equals 21, 22, 23, or 24.
MC	MC069	Discharge Date	Required for all inpatient claims CCYYMMDD	3764	Discharge Date is required when Type of Bill on Facility Claims equals 011x, 018x, 021x, 028x, 041x, 065x, 066x, 084x, 086x, 089x or Type of Claim = 002 and cannot be less than the Admission Date.
MC	MC069	Discharge Date	Required for all inpatient claims CCYYMMDD	2570	Discharge Date must be in date format (YYYYMMDD) and cannot be a future date.
MC	MC070	Service PV Country Code	Country Code of PV - preferably practice location	3853	The Service PV Country Code must be within the valid domain of values.
MC	MC070	Service PV Country Code	Country Code of PV - preferably practice location	2159	Service PV Country Code is required.
MC	MC071	DRG	DRG	3783	The DRG is required when Type of Bill on Facility Claims (MC036) equals 011x, 018x, 021x, 028x, 041x, 065x, 066x, 084x, 086x or 089x Discharge Hour (MC022) and Discharge Status (MC023) are populated.

File Type	Element	Element Name	Element Description	Edit ID	Message
MC	MC072	DRG Version	Version number of the grouper used	3854	The DRG Version is required when DRG (MC071) is present.
MC	MC073	APC	APC	3867	APC is required when Type of Claim(MC094) = 002 and the Type of Bill on Facility Claims is 12, 13, 14, 22, 23, 32, 33, 34, 43, 71, 72, 73, 74, 75, 76, 79, 81, 82, 83 or 85 .
MC	MC074	APC Version	APC Version	3868	APC Version is required when APC is populated.
MC	MC075	Drug Code	Drug Code	2006	Drug Code must be within the valid domain of values.
MC	MC076	Billing PV Number	Payer assigned billing PV number.	2165	Billing PV Number is required.
MC	MC077	National Billing PV ID	National PV ID.	2166	National Billing PV ID is required.
MC	MC077	National Billing PV ID	National PV ID.	3665	National Billing PV ID must be ten digits long and numeric
MC	MC078	Billing PV Last Name or Organization Name	Full name of PV organization or last name of individual PV.	2167	Billing PV Last Name or Organization Name is required.
MC	MC079	PR ID Number	Must correspond to the PR file.	2168	PR ID Number is required.
MC	MC080	Reason for Adjustment	Codes to be developed.	2169	Reason for Adjustment is required.
MC	MC080	Reason for Adjustment	Codes to be developed.	3739	Reason for adjustment must be within the valid domain of values.
MC	MC081	Capitated Encounter Flag	Payment for this service is covered under a capitated arrangement. (Yes = 1, No = 0).	2701	Capitated Encounter Flag must be within the valid domain of values.
MC	MC081	Capitated Encounter Flag	Payment for this service is covered under a capitated arrangement. (Yes = 1, No = 0).	2616	Capitated Encounter Flag must be in integer (no decimal points) format .
MC	MC081	Capitated Encounter Flag	Payment for this service is covered under a capitated arrangement. (Yes = 1, No = 0).	2170	Capitated Encounter Flag is required.
MC	MC082	Member Street Address	Street address of member; used for internal geocoding processes; not released.	2171	Member Street Address is required.
MC	MC083	Other ICD-9-CM Procedure Code - 1	Other ICD-9-CM Procedure Code - 1	2008	Other ICD-9-CM Procedure Code - 1 must be within the valid domain of values.
MC	MC084	Other ICD-9-CM Procedure Code - 2	Other ICD-9-CM Procedure Code - 2	2009	Other ICD-9-CM Procedure Code - 2 must be within the valid domain of values.
MC	MC085	Other ICD-9-CM Procedure Code - 3	Other ICD-9-CM Procedure Code - 3	2010	Other ICD-9-CM Procedure Code - 3 must be within the valid domain of values.
MC	MC086	Other ICD-9-CM Procedure Code - 4	Other ICD-9-CM Procedure Code - 4	2011	Other ICD-9-CM Procedure Code - 4 must be within the valid domain of values.

File Type	Element	Element Name	Element Description	Edit ID	Message
MC	MC087	Other ICD-9-CM Procedure Code - 5	Other ICD-9-CM Procedure Code - 5	2012	Other ICD-9-CM Procedure Code - 5 must be within the valid domain of values.
MC	MC088	Other ICD-9-CM Procedure Code - 6	Other ICD-9-CM Procedure Code - 6	2013	Other ICD-9-CM Procedure Code - 6 must be within the valid domain of values.
MC	MC089	Paid Date	Paid Date	3658	Paid Date must be between the Period Begin and Period End Dates on the Transmittal Record.
MC	MC089	Paid Date	Paid Date	2178	Paid Date is required.
MC	MC089	Paid Date	Paid Date	2571	Paid Date must be in date format (YYYYMMDD) and cannot be a future date.
MC	MC090	LOINC Code	LOINC Code	3860	The LOINC Code must be within the valid domain of values.
MC	MC092	Covered Days	Amount of inpatient days paid for by carrier..	3666	Covered Days is required when Type of Claim (MC094) = 002 or when Type of Bill on Facility Claims (MC036) equals 011x, 018x, 021x, 028x, 041x, 065x, 066x, 084x, 086x or 089x.
MC	MC092	Covered Days	Amount of inpatient days paid for by carrier..	2617	Covered Days must be in integer (no decimal points) format and cannot be negative.
MC	MC093	Non Covered Days	Amount of inpatient days that were not paid for by plan for the inpatient event.	2618	Non Covered Days must be in integer (no decimal points) format and cannot be negative.
MC	MC093	Non Covered Days	Amount of inpatient days that were not paid for by plan for the inpatient event.	3667	The Non Covered Days is required when Type of Claim (MC094) = 002 and Type of Bill on Facility Claims (MC036) = 011x, 018x, 021x, 028x, 041x, 065x, 066x, 084x, 086x or 089x.
MC	MC094	Type of Claim	Type of Claim	2702	Type of Claim must be within the valid domain of values.
MC	MC094	Type of Claim	Type of Claim	2183	Type of Claim is required.
MC	MC095	Coordination of Benefits/TPL Liability Amount	Coordination of Benefits/TPL Liability Amount	2619	Coordination of Benefits/TPL Liability Amount must be in integer (no decimal points) format and cannot be zero.
MC	MC095	Coordination of Benefits/TPL Liability Amount	Coordination of Benefits/TPL Liability Amount	3784	The Coordination Of Benefits TPL Liability Amount is required when Claim Status (MC038) equals 19, 20 or 21.
MC	MC096	Other Insurance Paid Amount	Other Insurance Paid Amount	3785	The Other Insurance Paid Amount is required when Claim Status (MC038) equals 02, 03, 20, 21.
MC	MC096	Other Insurance Paid Amount	Other Insurance Paid Amount	2620	Other Insurance Paid Amount must be in integer (no decimal points) format .
MC	MC097	Medicare Paid Amount	Medicare Paid Amount	2621	Medicare Paid Amount must be in integer (no decimal points) format and cannot be negative.

File Type	Element	Element Name	Element Description	Edit ID	Message
MC	MC097	Medicare Paid Amount	Medicare Paid Amount	3786	The Medicare Paid Amount is required when Medicare Indicator = Y.
MC	MC098	Allowed Amount	Allowed Amount	3787	The Allowed amount is required when Claim Status does not equal 04 or 22.
MC	MC098	Allowed Amount	Allowed Amount	2622	Allowed Amount must be in integer (no decimal points) format and cannot be zero.
MC	MC099	Non-Covered Amount	Dollar amount that was charged that is above the plans limitations.	2623	Non-Covered Amount must be in integer (no decimal points) format and cannot be zero.
MC	MC099	Non-Covered Amount	Dollar amount that was charged that is above the plans limitations.	3788	The Non Covered amount is required when Claim Status equals 04 or 22.
MC	MC100	Delegated Benefit Administrator Organization ID	If the record is sourced from a delegated benefit administrator, this field contains the DHCFP assigned organization ID for the delegated benefit administrator. Contact DHCFP for the appropriate value. Report null values if not applicable.	3861	When present, the DelegatedBenefitAdministratorOrganizationID must be a valid orgid.
MC	MC100	Delegated Benefit Administrator Organization ID	If the record is sourced from a delegated benefit administrator, this field contains the DHCFP assigned organization ID for the delegated benefit administrator. Contact DHCFP for the appropriate value. Report null values if not applicable.	3914	Delegated Benefit Administrator Organization ID must be in integer (no decimal points) format.
MC	MC101	Subscriber Last Name	Used to create unique member ID and for internal validation processes.	2190	Subscriber Last Name is required.
MC	MC102	Subscriber First Name	Used to create unique member ID and for internal validation processes.	2191	Subscriber First Name is required.
MC	MC104	Member Last Name	Used to create unique member ID and for internal validation processes.	2193	Member Last Name is required.
MC	MC105	Member First Name	Used to create unique member ID and for internal validation processes.	2194	Member First Name is required.
MC	MC108	Procedure Modifier - 3	Procedure Modifier - 3	2017	Procedure Modifier - 3 must be within the valid domain of values.
MC	MC109	Procedure Modifier - 4	Procedure Modifier - 4	2018	Procedure Modifier - 4 must be within the valid domain of values.
MC	MC110	Claim Processed Date	Claim Processed Date	2199	Claim Processed Date is required.
MC	MC110	Claim Processed Date	Claim Processed Date	2572	Claim Processed Date must be in date format (YYYYMMDD) and cannot be a future date.
MC	MC111	Diagnostic Pointer	Diagnostic Pointer	3878	Diagnostic Pointer is required when Type of Claim (MC094) = 001.

File Type	Element	Element Name	Element Description	Edit ID	Message
MC	MC112	Referring PV ID	The identifier of the PV that submitted the referral for service to the specialist.	3789	The Referring PV ID is required when the Referral Indicator (MC118) equals 1.
MC	MC113	Payment Arrangement Type	Payment Arrangement Type	2019	Payment Arrangement Type must be within the valid domain of values.
MC	MC113	Payment Arrangement Type	Payment Arrangement Type	2202	Payment Arrangement Type is required.
MC	MC114	Excluded Expenses	Amount not covered due to plan limitations.	2203	Excluded Expenses is required.
MC	MC114	Excluded Expenses	Amount not covered due to plan limitations.	2624	Excluded Expenses must be in integer (no decimal points) format and cannot be negative.
MC	MC115	Medicare Indicator	Indicates if Medicare paid for part or all of services.	2204	Medicare Indicator is required.
MC	MC115	Medicare Indicator	Indicates if Medicare paid for part or all of services.	2703	Medicare Indicator must be within the valid domain of values.
MC	MC116	Withhold Amount	The amount to be paid to PV for this service is the PV qualifies/meets performance guarantees.	2625	Withhold Amount must be in integer (no decimal points) format and cannot be negative.
MC	MC117	Authorization Needed	Indicates if service required a pre authorization.	2206	Authorization Needed is required.
MC	MC117	Authorization Needed	Indicates if service required a pre authorization.	2626	Authorization Needed must be in integer (no decimal points) format .
MC	MC117	Authorization Needed	Indicates if service required a pre authorization.	2704	Authorization Needed must be within the valid domain of values.
MC	MC118	Referral Indicator	Indicates if service was preceded by a referral.	2705	Referral Indicator must be within the valid domain of values.
MC	MC118	Referral Indicator	Indicates if service was preceded by a referral.	2207	Referral Indicator is required.
MC	MC119	PCP Indicator	Indicates if service performed by members PCP.	2208	PCP Indicator is required.
MC	MC119	PCP Indicator	Indicates if service performed by members PCP.	2706	PCP Indicator must be within the valid domain of values.
MC	MC122	Global Payment Flag	Global Payment Flag	2707	Global Payment Flag must be within the valid domain of values.
MC	MC122	Global Payment Flag	Global Payment Flag	2211	Global Payment Flag is required.
MC	MC123	Denied Flag	Denied Flag indicating claim was denied.	2212	Denied Flag is required.
MC	MC123	Denied Flag	Denied Flag indicating claim was denied.	2708	Denied Flag must be within the valid domain of values.
MC	MC124	Denial Reason	Denial Reason	3747	Denial Reason must be within the valid domain of values.
MC	MC124	Denial Reason	Denial Reason	3812	The Denial Reason is required when the Denied Flag (MC123) = 1.
MC	MC125	Attending PV	Attending PV for hospital claims	3668	Attending PV is required when Type of Bill on Facility Claims equals 011x, 018x, 021x, 028x, 041x, 065x, 066x, 084x, 086x, or 089x and Type of Claim = 002

File Type	Element	Element Name	Element Description	Edit ID	Message
MC	MC126	Accident Indicator	Indicates if service is related to an accident rather than an illness.	2709	Accident Indicator must be within the valid domain of values.
MC	MC126	Accident Indicator	Indicates if service is related to an accident rather than an illness.	2215	Accident Indicator is required.
MC	MC127	Family Planning Indicator	A flag that indicates if family planning services were provided.	2023	Family Planning Indicator must be within the valid domain of values.
MC	MC127	Family Planning Indicator	A flag that indicates if family planning services were provided.	3869	The Family Planning Indicator is required when Type of Claim = 001.
MC	MC128	Employment Related Indicator	Flag indicating is claim was related to employment accident.	2710	Employment Related Indicator must be within the valid domain of values.
MC	MC128	Employment Related Indicator	Flag indicating is claim was related to employment accident.	2217	Employment Related Indicator is required.
MC	MC129	EPSDT Indicator	A flag that indicates if service was related to EPSDT and the type of EPSDT service such as screening, treatment or referral.	2024	EPSDT Indicator must be within the valid domain of values.
MC	MC129	EPSDT Indicator	A flag that indicates if service was related to EPSDT and the type of EPSDT service such as screening, treatment or referral.	3870	The EPSDT Indicator is required when Type of Claim = 001.
MC	MC130	Procedure Code Type	Pick CPT, HCPCS, Rev Code, etc.	2711	Procedure Code Type must be within the valid domain of values.
MC	MC130	Procedure Code Type	Pick CPT, HCPCS, Rev Code, etc.	2219	Procedure Code Type is required.
MC	MC131	InNetwork Indicator	Indicates if the claims was paid at in or out of network rates or if there is no network.	2220	InNetwork Indicator is required.
MC	MC131	InNetwork Indicator	Indicates if the claims was paid at in or out of network rates or if there is no network.	2712	InNetwork Indicator must be within the valid domain of values.
MC	MC132	Service Class	Field used to define service class for Medicaid PCC members receiving behavioral health.	2026	Service Class must be within the valid domain of values.
MC	MC134	Plan Rendering PV Identifier	Unique code which identifies for the carrier who or which individual PV cared for the patient for the claim line in question. This code must be able to link to the PV file. Any value in this field must also show up as a value in field PV002.	2223	Plan Rendering PV Identifier is required.
MC	MC135	PV Location	Unique code which identifies the location/site of the service provided identified in MC134. The code should link to a PV record in PV002 (PV ID) and indicate that the service was performed at a specific location; eg: Dr.	2224	PV Location is required.

File Type	Element	Element Name	Element Description	Edit ID	Message
MC	MC136	Discharge Diagnosis	The ICD9 Diagnosis code given to a member upon discharge, which may or may not be the same as the primary diagnosis and admitting diagnosis.	3736	DischargeDiagnosis must be within the valid domain of values.
MC	MC136	Discharge Diagnosis	The ICD9 Diagnosis code given to a member upon discharge, which may or may not be the same as the primary diagnosis and admitting diagnosis.	3790	The Discharge Diagnosis is required when the Type of Bill on Facility Claims equals 11, 18, 21, 28, 41, 65, 66, 84, 86, or 89 and the Type of Claim = 002 and when the Discharge Status (MC023) does not equal 30.
MC	MC137	Carrier Specific Unique Member ID	This is the number the carrier uses internally to uniquely identify the member. This field will be encrypted.	2226	Carrier Specific Unique Member ID is required.
MC	MC138	Claim Line Type	Code indicating type of record.	2227	Claim Line Type is required.
MC	MC138	Claim Line Type	Code indicating type of record.	2713	Claim Line Type must be within the valid domain of values.
MC	MC139	Former Claim Number	If this is not an original claim, the previous claim number that this claim is replacing/voiding.	3855	The Former Claim Number is required when Claim Line Type (MC138) = V, R, B, or A.
MC	MC140	Member address 2	Address of member, which may include apartment number or suite, or other secondary information besides the street.	3814	The Member Address 2 is required when the Member Street Address (MC082) is not present.
MC	MC141	Carrier Specific Unique Subscriber ID	This is the number the carrier uses internally to uniquely identify the subscriber. This field will be encrypted.	2230	Carrier Specific Unique Subscriber ID is required.
MC	MC899	Record Type	MC	3669	Record Type must match the Record Type on the Header and the Record Type on the Trailer
MC	MC899	Record Type	MC	2231	Record Type is required.
ME	ME001	Payer	Payer submitting payments, Council Submitter Code	211	The Payer Field within each record of the file must match the Payer Field on the Header Record.
ME	ME001	Payer	Payer submitting payments, Council Submitter Code	2383	Payer is required.
ME	ME002	National Plan ID	CMS National Plan ID	3670	The National Plan ID within each record of the file must match the National Plan ID on the Header Record.
ME	ME003	Insurance Type Code/PR	See tlkpInsuranceType	1947	Insurance Type Code/PR must be within the valid domain of values.
ME	ME003	Insurance Type Code/PR	See tlkpInsuranceType	2385	Insurance Type Code/PR is required.
ME	ME004	Year	Year for which eligibility is reported in this submission	2660	Year must be in integer (no decimal points) format .
ME	ME004	Year	Year for which eligibility is reported in this submission	2386	Year is required.
ME	ME004	Year	Year for which eligibility is reported in this submission	3671	Year must be 4 digits and be within the begin and end date on the header file.

File Type	Element	Element Name	Element Description	Edit ID	Message
ME	ME005	Month	Month for which eligibility is reported in this submission	2387	Month is required.
ME	ME005	Month	Month for which eligibility is reported in this submission	2661	Month must be in integer (no decimal points) format, cannot be negative and cannot be zero.
ME	ME006	Insured Group or Policy Number	Group or policy number (not the number that uniquely identifies the subscriber)	2388	Insured Group or Policy Number is required.
ME	ME007	Coverage Level Code	See tlkpCoverage	2389	Coverage Level Code is required.
ME	ME007	Coverage Level Code	See tlkpCoverage	1948	Coverage Level Code must be within the valid domain of values.
ME	ME008	Subscriber Unique Identification Number	Subscriber's unique identification number (set as null if unavailable)	3733	SubscriberUniqueIdentificationNumber must be 9 digits and numeric.
ME	ME008	Subscriber Unique Identification Number	Subscriber's unique identification number (set as null if unavailable)	2390	Subscriber Unique Identification Number is required.
ME	ME008	Subscriber Unique Identification Number	Subscriber's unique identification number (set as null if unavailable)	3903	Subscriber Unique Identification Number must be in integer (no decimal points) format, cannot be zero and cannot be negative.
ME	ME009	Plan Specific Contract Number	Plan assigned contract number (set as null if contract number = subscriber's social security number)	2391	Plan Specific Contract Number is required.
ME	ME010	Member Suffix or Sequence Number	Uniquely numbers the member within the contract	2392	Member Suffix or Sequence Number is required.
ME	ME011	Member Identification Code	Encrypted member's unique identification number (set as null if unavailable)	2393	Member Identification Code is required.
ME	ME011	Member Identification Code	Encrypted member's unique identification number (set as null if unavailable)	3734	MemberIdentificationCode must be 9 digits and numeric.
ME	ME011	Member Identification Code	Encrypted member's unique identification number (set as null if unavailable)	3904	Member Identification Code must be in integer (no decimal points) format, cannot be zero and cannot be negative.
ME	ME012	Individual Relationship Code	Member's relationship to insured as in tlkpEligibilityIndividualRelationship	1949	Individual Relationship Code must be within the valid domain of values.
ME	ME012	Individual Relationship Code	Member's relationship to insured as in tlkpEligibilityIndividualRelationship	2394	Individual Relationship Code is required.
ME	ME012	Individual Relationship Code	Member's relationship to insured as in tlkpEligibilityIndividualRelationship	2662	Individual Relationship Code must be in integer (no decimal points) format .
ME	ME013	Member Gender	M Male	2395	Member Gender is required.
ME	ME013	Member Gender	M Male	1950	Member Gender must be within the valid domain of values.

File Type	Element	Element Name	Element Description	Edit ID	Message
ME	ME014	Member Date of Birth	CCYYMMDD	3844	The Member Date of Birth cannot be a future date.
ME	ME014	Member Date of Birth	CCYYMMDD	2396	Member Date of Birth is required.
ME	ME014	Member Date of Birth	CCYYMMDD	2583	Member Date of Birth must be in date format (YYYYMMDD) and cannot be a future date.
ME	ME015	Member City Name	City name of member	2397	Member City Name is required.
ME	ME016	Member State or Province	As defined by the US Postal Service	2398	Member State or Province is required.
ME	ME016	Member State or Province	As defined by the US Postal Service	3845	The Member State or Province must be within the valid domain of values.
ME	ME017	Member ZIP Code	ZIP Code of member – may include non-US codes. (Do not include dash)	3846	The Member ZIP Code must be within the valid domain of values.
ME	ME017	Member ZIP Code	ZIP Code of member – may include non-US codes. (Do not include dash)	3847	The Subscriber State or Province must be within the valid domain of values.
ME	ME017	Member ZIP Code	ZIP Code of member – may include non-US codes. (Do not include dash)	2399	Member ZIP Code is required.
ME	ME018	Medical Coverage	Y = Yes, N = No	2400	Medical Coverage is required.
ME	ME018	Medical Coverage	Y = Yes, N = No	1951	Medical Coverage must be within the valid domain of values.
ME	ME019	Prescription Drug Coverage	Y = Yes, N = No	1952	Prescription Drug Coverage must be within the valid domain of values.
ME	ME019	Prescription Drug Coverage	Y = Yes, N = No	2401	Prescription Drug Coverage is required.
ME	ME020	Dental Coverage	Dental Coverage: Y/N	2685	Dental Coverage must be within the valid domain of values.
ME	ME020	Dental Coverage	Dental Coverage: Y/N	2402	Dental Coverage is required.
ME	ME021	Race 1	See tlkpRace	2403	Race 1 is required.
ME	ME021	Race 1	See tlkpRace	1953	Race 1 must be within the valid domain of values.
ME	ME022	Race 2	See tlkpRace	1954	Race 2 must be within the valid domain of values.
ME	ME022	Race 2	See tlkpRace	2404	Race 2 is required.
ME	ME023	Other Race	Patient Race, if Race 1 or Race 2 is entered as R9 Other Race (set as null if none)	3815	The Other Race is required when the Race 2 (ME022) or Race 1 (ME021) = R9.
ME	ME024	Hispanic Indicator	Hispanic Indicator	1955	Hispanic Indicator must be within the valid domain of values.
ME	ME024	Hispanic Indicator	Hispanic Indicator	2406	Hispanic Indicator is required.

File Type	Element	Element Name	Element Description	Edit ID	Message
ME	ME025	Ethnicity 1	See tlkpEthnicity	2407	Ethnicity 1 is required.
ME	ME025	Ethnicity 1	See tlkpEthnicity	1956	Ethnicity 1 must be within the valid domain of values.
ME	ME026	Ethnicity 2	See tlkpEthnicity	1957	Ethnicity 2 must be within the valid domain of values.
ME	ME026	Ethnicity 2	See tlkpEthnicity	2408	Ethnicity 2 is required.
ME	ME027	Other Ethnicity	Patient Ethnicity if Ethnicity 1 or Ethnicity 2 is entered as OTHER Ethnicity. (set as null if none)	3816	The Other Ethnicity is required when the Ethnicity 1 (ME025) or Ethnicity 1 (ME026) = Other.
ME	ME028	Primary Insurance Indicator	Primary Insurance Indicator	2686	Primary Insurance Indicator must be within the valid domain of values.
ME	ME028	Primary Insurance Indicator	Primary Insurance Indicator	2410	Primary Insurance Indicator is required.
ME	ME029	Coverage Type	Fully insured, self-insured, etc..	2411	Coverage Type is required.
ME	ME029	Coverage Type	Fully insured, self-insured, etc..	2027	Coverage Type must be within the valid domain of values.
ME	ME030	Market Category Code	Type of market and group size.	2028	Market Category Code must be within the valid domain of values.
ME	ME030	Market Category Code	Type of market and group size.	2412	Market Category Code is required.
ME	ME031	Special Coverage	Special Coverage	2687	Special Coverage must be within the valid domain of values.
ME	ME033	Member Language Preference	Member Language Preference	1991	Member Language Preference must be within the valid domain of values.
ME	ME033	Member Language Preference	Member Language Preference	2415	Member Language Preference is required.
ME	ME034	Member Language Preference -- Other	Member Language Preference -- Other	3817	The Other Language Preference is required when the Member Language Preference (ME033) = Other.
ME	ME035	Health Care Home Assigned Flag	Indicates if member has been assigned a medical/healthcare home.	2688	Health Care Home Assigned Flag must be within the valid domain of values.
ME	ME035	Health Care Home Assigned Flag	Indicates if member has been assigned a medical/healthcare home.	2417	Health Care Home Assigned Flag is required.
ME	ME036	Health Care Home Number	Filled when healthcare home is assigned.	3791	The Health Care Home Number is required when Home Health Care Assigned Flag (ME035) equals 1.
ME	ME037	Health Care Home Tax ID Number	Filled when healthcare home is assigned.	3792	The Health Care Home Tax ID Number is required when Home Health Care Assigned Flag (ME035) equals 1.
ME	ME037	Health Care Home Tax ID Number	Filled when healthcare home is assigned.	3905	Health Care Home Tax ID Number must be in integer (no decimal points) format, cannot be zero and cannot be negative.

File Type	Element	Element Name	Element Description	Edit ID	Message
ME	ME038	Health Care Home National PV ID	Filled when healthcare home is assigned.	3793	The Health Care National PV ID is required (and must be 10 numbers long) when Home Health Care Assigned Flag (ME035) equals 1.
ME	ME039	Health Care Home Name	Filled when healthcare home is assigned.	3794	The Health Care Home Name is required when Home Health Care Assigned Flag (ME035) equals 1.
ME	ME040	PR ID Number	Corresponds to the PR file data element PR003.	2422	PR ID Number is required.
ME	ME041	PR Enrollment Start Date	PR Enrollment Start Date	2423	PR Enrollment Start Date is required.
ME	ME041	PR Enrollment Start Date	PR Enrollment Start Date	2584	PR Enrollment Start Date must be in date format (YYYYMMDD) and cannot be a future date.
ME	ME042	PR Enrollment End Date	PR Enrollment End Date	2585	PR Enrollment End Date must be in date format (YYYYMMDD).
ME	ME042	PR Enrollment End Date	PR Enrollment End Date	3677	If not NULL, Enrollment End Date must be > Enrollment Start Date
ME	ME043	Member Street Address	Member Street Address	2425	Member Street Address is required.
ME	ME046	Member PCP ID	Member PCP ID	3678	Member PCP ID must be present when Member PCP Effective Date (ME047) is present.
ME	ME047	Member PCP Effective Date	Member enrollment begin date with PCP.	3679	Member PCP Effective Date is required when Member PCP ID does not equal 999999999U.
ME	ME047	Member PCP Effective Date	Member enrollment begin date with PCP.	2586	Member PCP Effective Date must be in date format (YYYYMMDD) and cannot be a future date.
ME	ME048	Member PCP Termination Date	Member termination date from that PCP.	2587	Member PCP Termination Date must be in date format (YYYYMMDD).
ME	ME048	Member PCP Termination Date	Member termination date from that PCP.	3680	If not Null, Member PCP Termination Date cannot be prior to the Member PCP Effective date.
ME	ME049	Member Deductible	Amount of member's annual deductible (could also be interpreted from PR file).	2663	Member Deductible must be in integer (no decimal points) format and cannot be negative.
ME	ME050	Member Deductible Used	The amount to date the member has paid into deductible. This helps determine utilization patterns before and after the member meets their annual deductible..	2664	Member Deductible Used must be in integer (no decimal points) format and cannot be negative.
ME	ME050	Member Deductible Used	The amount to date the member has paid into deductible. This helps determine utilization patterns before and after the member meets their annual deductible..	3818	The Member Deductible Used is required when the Member Deductible (ME049) is greater than zero.

File Type	Element	Element Name	Element Description	Edit ID	Message
ME	ME051	Behavioral Health Benefit Flag	Indicates if BH is covered benefit.	2689	Behavioral Health Benefit Flag must be within the valid domain of values.
ME	ME051	Behavioral Health Benefit Flag	Indicates if BH is covered benefit.	2433	Behavioral Health Benefit Flag is required.
ME	ME051	Behavioral Health Benefit Flag	Indicates if BH is covered benefit.	2665	Behavioral Health Benefit Flag must be in integer (no decimal points) format .
ME	ME052	Laboratory Benefit Flag	dictates if lab is covered benefit.	2434	Laboratory Benefit Flag is required.
ME	ME052	Laboratory Benefit Flag	dictates if lab is covered benefit.	2690	Laboratory Benefit Flag must be within the valid domain of values.
ME	ME053	Disease Management Enrollee Flag	Determines if the member's chronic illness is being managed by a vendor.	2697	Disease Management Enrollee Flag must be within the valid domain of values.
ME	ME053	Disease Management Enrollee Flag	Determines if the member's chronic illness is being managed by a vendor.	2435	Disease Management Enrollee Flag is required.
ME	ME053	Disease Management Enrollee Flag	Determines if the member's chronic illness is being managed by a vendor.	2666	Disease Management Enrollee Flag must be in integer (no decimal points) format .
ME	ME054	Eligibility Determination Date	Date ME determined.	2588	Eligibility Determination Date must be in date format (YYYYMMDD) and cannot be a future date.
ME	ME054	Eligibility Determination Date	Date ME determined.	3682	Eligibility Determination Date cannot be greater than the month of the submission file
ME	ME054	Eligibility Determination Date	Date ME determined.	3766	Eligibility Determination Date is cannot be before the PR Enrollment Date (ME041).
ME	ME056	Last Activity Date	Last activity/change on member enrollment file for this member.	3683	Last Activity Date cannot be greater than the month of the submission file
ME	ME056	Last Activity Date	Last activity/change on member enrollment file for this member.	2589	Last Activity Date must be in date format (YYYYMMDD) and cannot be a future date.
ME	ME057	Date of Death	Date member expired.	3684	If not Null, Date of death cannot be greater than the month of the submission file
ME	ME057	Date of Death	Date member expired.	2590	Date of Death must be in date format (YYYYMMDD) and cannot be a future date.
ME	ME058	Subscriber Street Address	Address of the subscriber.	2440	Subscriber Street Address is required.
ME	ME059	Disability Indicator Flag	Determines if there is a disability claim for this member?	2441	Disability Indicator Flag is required.

File Type	Element	Element Name	Element Description	Edit ID	Message
ME	ME059	Disability Indicator Flag	Determines if there is a disability claim for this member?	2667	Disability Indicator Flag must be in integer (no decimal points) format .
ME	ME059	Disability Indicator Flag	Determines if there is a disability claim for this member?	2692	Disability Indicator Flag must be within the valid domain of values.
ME	ME060	Employment Status	active, retired, leave	2693	Employment Status must be within the valid domain of values.
ME	ME061	Student Status	Determines if member is a student.	2694	Student Status must be within the valid domain of values.
ME	ME061	Student Status	Determines if member is a student.	2443	Student Status is required.
ME	ME062	Marital Status	Shows marital status of member.	2039	Marital Status must be within the valid domain of values.
ME	ME062	Marital Status	Shows marital status of member.	2444	Marital Status is required.
ME	ME063	Benefit Status	determines status of benefits for employee.	2445	Benefit Status is required.
ME	ME063	Benefit Status	determines status of benefits for employee.	2695	Benefit Status must be within the valid domain of values.
ME	ME064	Employee Type	(eg: hourly, salaried, temp)	2040	Employee Type must be within the valid domain of values.
ME	ME064	Employee Type	(eg: hourly, salaried, temp)	2446	Employee Type is required.
ME	ME065	Date of Retirement	Date GIC employee retired	2591	Date of Retirement must be in date format (YYYYMMDD).
ME	ME065	Date of Retirement	Date GIC employee retired	3795	The Date of Retirement is required when Employment Status (ME060) equals Retiree.
ME	ME066	COBRA Status	Indicates if member is covered using COBRA benefit.	2696	COBRA Status must be within the valid domain of values.
ME	ME066	COBRA Status	Indicates if member is covered using COBRA benefit.	2448	COBRA Status is required.
ME	ME066	COBRA Status	Indicates if member is covered using COBRA benefit.	2668	COBRA Status must be in integer (no decimal points) format .
ME	ME067	Spouse Plan Type	Used when spouse of employee selects Medicare coverage, which is separate from GIC.	2041	Spouse Plan Type must be within the valid domain of values.
ME	ME068	Spouse Plan	when spouse of employee selects Medicare coverage, which is separate from GIC..	2726	Spouse Plan must be within the valid domain of values.
ME	ME069	Spouse Medical Coverage	Used when spouse of employee selects Medicare coverage, which is separate from GIC.	2727	Spouse Medical Coverage must be within the valid domain of values.
ME	ME070	Spouse Medicare Indicator	Used when spouse of employee selects Medicare coverage, which is separate from GIC.	2728	Spouse Medicare Indicator must be within the valid domain of values.
ME	ME073	Fully Insured Member	1 = Yes, Member is fully insured	2043	Fully Insured Member must be within the valid domain of values.
ME	ME073	Fully Insured Member	1 = Yes, Member is fully insured	2455	Fully Insured Member is required.
ME	ME074	Interpreter	Does member require interpreter	3722	Interpreter must be within the valid domain of values.

File Type	Element	Element Name	Element Description	Edit ID	Message
ME	ME075	NewMMISID	This is the unique ID that NewMMIS uses to uniquely identify a member. (This field is for MassHealth, Medicaid MCOs, or Carriers that offer Commonwealth Care.)	3685	NewMMIS ID must be in valid format and length and is required when Year (ME004) and Month (ME005) is greater than 200904.
ME	ME076	Member rating category		2044	Member rating category must be within the valid domain of values.
ME	ME081	Medicare Code	A code indicating if Medicare coverage applies and, if so, the type of Medicare coverage.	2698	Medicare Code must be within the valid domain of values.
ME	ME081	Medicare Code	A code indicating if Medicare coverage applies and, if so, the type of Medicare coverage.	2463	Medicare Code is required.
ME	ME083	Employer EIN	Employer EIN	3906	Employer EIN must be in integer (no decimal points) format, cannot be zero and cannot be negative.
ME	ME101	Subscriber Last Name	Subscriber Last Name	2466	Subscriber Last Name is required.
ME	ME102	Subscriber First Name	Subscriber First Name	2467	Subscriber First Name is required.
ME	ME103	Subscriber Middle Initial	Subscriber Middle Initial	2468	Subscriber Middle Initial is required.
ME	ME104	Member Last Name	Member Last Name	2469	Member Last Name is required.
ME	ME105	Member First Name	Member First Name	2470	Member First Name is required.
ME	ME106	Member Middle Initial	Member Middle Initial	2471	Member Middle Initial is required.
ME	ME107	Carrier Specific Unique Member ID	This is the number the carrier uses internally to uniquely identify the member. This field will be encrypted upon intake.	2472	Carrier Specific Unique Member ID is required.
ME	ME108	Subscriber City Name	Subscriber City Name	2473	Subscriber City Name is required.
ME	ME109	Subscriber State or Province	The state of the subscriber's residence. As defined by the US Postal Service	2474	Subscriber State or Province is required.
ME	ME110	Subscriber ZIP Code	5 or 9 digit Zip Code as defined by the United States Postal Service. When submitting the 9-digit Zip Code do not include hyphen; see External Code Source	2475	Subscriber ZIP Code is required.
ME	ME110	Subscriber ZIP Code	5 or 9 digit Zip Code as defined by the United States Postal Service. When submitting the 9-digit Zip Code do not include hyphen; see External Code Source	3687	Subscriber ZIP Code must match Subscriber City Name

File Type	Element	Element Name	Element Description	Edit ID	Message
ME	ME111	Medical Deductible	The annual amount of the member's deductible that is applied to medical services before certain services are covered. This is the Base Deductible for General Services. Code zero cents (00) where applicable. Example: 150.00 will be reported as 15000.	3796	The Medical Deductible is required when Medical Coverage (ME018) equals 1.
ME	ME111	Medical Deductible	The annual amount of the member's deductible that is applied to medical services before certain services are covered. This is the Base Deductible for General Services. Code zero cents (00) where applicable. Example: 150.00 will be reported as 15000.	2669	Medical Deductible must be in integer (no decimal points) format and cannot be negative.
ME	ME112	Pharmacy Deductible	The annual amount of the member's deductible that is applied to pharmacy before certain prescriptions are covered. If patient deductible only applies to medical services then fill this field with 0. This is the Base Deductible for General Services. Code zero cents (00) where applicable. Example: 150.00 will be reported as 15000	2670	Pharmacy Deductible must be in integer (no decimal points) format and cannot be negative.
ME	ME112	Pharmacy Deductible	The annual amount of the member's deductible that is applied to pharmacy before certain prescriptions are covered. If patient deductible only applies to medical services then fill this field with 0. This is the Base Deductible for General Services. Code zero cents (00) where applicable. Example: 150.00 will be reported as 15000	3797	The Pharmacy Deductible is required when Pharmacy Coverage (ME019) equals 1.
ME	ME113	Medical and Pharmacy Deductible	This field should be filled in when the deductible is not strictly based on medical or strictly on pharmacy out of pocket costs, but on the combination of the two. If patient deductible only applies to medical services then fill this field with 0.This is the Base Deductible for General Services. Code zero cents (00) where applicable. Example: 150.00 will be reported as 15000.	3798	The Medical and Pharmacy Deductible is required when Medical and Pharmacy Coverage (ME018 and ME019) equal 1.
ME	ME113	Medical and Pharmacy Deductible	This field should be filled in when the deductible is not strictly based on medical or strictly on pharmacy out of pocket costs, but on the combination of the two. If patient deductible only applies to medical services then fill this field with 0.This is the Base Deductible for General Services. Code zero cents (00) where applicable. Example: 150.00 will be reported as 15000.	2671	Medical and Pharmacy Deductible must be in integer (no decimal points) format and cannot be negative.

File Type	Element	Element Name	Element Description	Edit ID	Message
ME	ME114	Behavioral Health Deductible	The annual amount of the member's deductible that is applied to behavioral health services before certain behavioral health services are covered. This is the Base Deductible for General Services.Code zero cents (00) where applicable. Example: 150.00 will be reported as 15000	2672	Behavioral Health Deductible must be in integer (no decimal points) format and cannot be negative.
ME	ME114	Behavioral Health Deductible	The annual amount of the member's deductible that is applied to behavioral health services before certain behavioral health services are covered. This is the Base Deductible for General Services.Code zero cents (00) where applicable. Example: 150.00 will be reported as 15000	3819	The Behavioral Health Deductible is required when the Behavioral Health Benefit Flag (ME051) equals 1.
ME	ME115	Dental Deductible	The annual amount of the member's deductible that is applied to dental services before certain dental services are covered. This is the Base Deductible for General Services. Code zero cents (00) where applicable. Example: 150.00 will be reported as 15000.	3877	Dental Deductible is required when Dental Coverage (ME020) = 1.
ME	ME115	Dental Deductible	The annual amount of the member's deductible that is applied to dental services before certain dental services are covered. This is the Base Deductible for General Services. Code zero cents (00) where applicable. Example: 150.00 will be reported as 15000.	2673	Dental Deductible must be in integer (no decimal points) format and cannot be negative.
ME	ME116	Vision Deductible	The annual amount of the member's deductible that is applied to vision services before certain vision services are covered. This is the Base Deductible for General Services. Code zero cents (00) where applicable. Example: 150.00 will be reported as 15000	2674	Vision Deductible must be in integer (no decimal points) format and cannot be negative.
ME	ME116	Vision Deductible	The annual amount of the member's deductible that is applied to vision services before certain vision services are covered. This is the Base Deductible for General Services. Code zero cents (00) where applicable. Example: 150.00 will be reported as 15000	3866	The Vision Deductible is required when Vision Benefit (ME118) = 1.
ME	ME117	Carrier Specific Unique Subscriber ID	This is the number the carrier uses internally to uniquely identify the subscriber. This field will be encrypted upon intake.	2482	Carrier Specific Unique Subscriber ID is required.
ME	ME118	Vision Benefit	1 = Yes, Vision is a covered benefit.	2483	Vision Benefit is required.
ME	ME118	Vision Benefit	1 = Yes, Vision is a covered benefit.	2675	Vision Benefit must be in integer (no decimal points) format .
ME	ME118	Vision Benefit	1 = Yes, Vision is a covered benefit.	2699	Vision Benefit must be within the valid domain of values.
ME	ME899	Record Type	ME	2484	Record Type is required.

File Type	Element	Element Name	Element Description	Edit ID	Message
ME	ME899	Record Type	ME	3723	RecordType must match the RecordType in the header and the trailer.
PC	PC001	Payer	Payer submitting payments , Council Submitter Code	1944	The Payer Field within each record of the file must match the Payer Field on the Header Record.
PC	PC001	Payer	Payer submitting payments , Council Submitter Code	2232	Payer is required.
PC	PC002	Plan ID	CMS National Plan ID	3688	Plan ID field must match the Plan ID on the Header Record
PC	PC003	Insurance Type Code/PR	See tlkpPharmacyInsuranceType	1979	Insurance Type Code/PR must be within the valid domain of values.
PC	PC003	Insurance Type Code/PR	See tlkpPharmacyInsuranceType	2234	Insurance Type Code/PR is required.
PC	PC004	Payer Claim Control Number	Must apply to the entire claim and be unique within the payer's system	2235	Payer Claim Control Number is required.
PC	PC005	Line Counter	Line number for this service	2236	Line Counter is required.
PC	PC005	Line Counter	Line number for this service	2627	Line Counter must be in integer (no decimal points) format , cannot be negative and cannot be zero.
PC	PC005A	Version Number	Claim Service Version Number.	2628	Version Number must be in integer (no decimal points) format and cannot be negative.
PC	PC005A	Version Number	Claim Service Version Number.	2237	Version Number is required.
PC	PC006	Insured Group or Policy Number	Group or policy number - not the number that uniquely identifies the subscriber	2238	Insured Group or Policy Number is required.
PC	PC007	Subscriber SSN	Subscribers social security number (set as null if unavailable); used to create unique member ID. If PC011=20 and PC107=PC108 this field is optional.	2239	Subscriber SSN is required.
PC	PC007	Subscriber SSN	Subscribers social security number (set as null if unavailable); used to create unique member ID. If PC011=20 and PC107=PC108 this field is optional.	3731	Subscriber SSN must be 9 digits, numeric and in valid format.
PC	PC007	Subscriber SSN	Subscribers social security number (set as null if unavailable); used to create unique member ID. If PC011=20 and PC107=PC108 this field is optional.	3907	Subscriber SSN must be in integer (no decimal points) format, cannot be zero and cannot be negative.
PC	PC008	Plan Specific Contract Number	Encrypted plan assigned contract number Set as null if contract number = subscriber's social security number	2240	Plan Specific Contract Number is required.
PC	PC009	Member Suffix or Sequence Number	Uniquely numbers the member within the contract	2241	Member Suffix or Sequence Number is required.
PC	PC010	Member SSN	Members social security number (set as null if unavailable)	2242	Member SSN is required.

File Type	Element	Element Name	Element Description	Edit ID	Message
PC	PC010	Member SSN	Members social security number (set as null if unavailable)	3730	Member SSN must be 9 digits, numeric and in valid format.
PC	PC010	Member SSN	Members social security number (set as null if unavailable)	3908	Member SSN must be in integer (no decimal points) format, cannot be zero and cannot be negative.
PC	PC011	Individual Relationship Code	See tlkpClaimIndividualRelationship	1980	Individual Relationship Code must be within the valid domain of values.
PC	PC011	Individual Relationship Code	See tlkpClaimIndividualRelationship	2243	Individual Relationship Code is required.
PC	PC011	Individual Relationship Code	See tlkpClaimIndividualRelationship	2629	Individual Relationship Code must be in integer (no decimal points) format .
PC	PC012	Member Gender	1 Male, 2 Female, 3 Unknown	2244	Member Gender is required.
PC	PC012	Member Gender	1 Male, 2 Female, 3 Unknown	1981	Member Gender must be within the valid domain of values.
PC	PC013	Member Date of Birth	CCYYMMDD	3833	The Member Date of Birth cannot be greater than the date of service.
PC	PC013	Member Date of Birth	CCYYMMDD	2245	Member Date of Birth is required.
PC	PC013	Member Date of Birth	CCYYMMDD	2573	Member Date of Birth must be in date format (YYYYMMDD) and cannot be a future date.
PC	PC014	Member City Name of Residence	City name of member	2246	Member City Name of Residence is required.
PC	PC015	Member State	As defined by the US Postal Service	2247	Member State is required.
PC	PC015	Member State	As defined by the US Postal Service	3834	The Member State must be within the valid domain of values.
PC	PC016	Member ZIP Code	ZIP Code of member - may include non-US codes. Do not include dash.	2248	Member ZIP Code is required.
PC	PC017	Date Service Approved (AP Date)	CCYYMMDD (Generally the same as the paid date or the Pharmacy Benefits Manager's billing date)	2249	Date Service Approved (AP Date) is required.
PC	PC017	Date Service Approved (AP Date)	CCYYMMDD (Generally the same as the paid date or the Pharmacy Benefits Manager's billing date)	2574	Date Service Approved (AP Date) must be in date format (YYYYMMDD).
PC	PC018	Pharmacy Number	pharmacy number (NCPDP or NABP)	2250	Pharmacy Number is required.
PC	PC019	Pharmacy Tax ID Number	Federal taxpayer's identification number. (Please provide the pharmacy chain's federal tax identification number, if the individual retail pharmacy's tax ID# is not available.)	2251	Pharmacy Tax ID Number is required.

File Type	Element	Element Name	Element Description	Edit ID	Message
PC	PC019	Pharmacy Tax ID Number	Federal taxpayer's identification number. (Please provide the pharmacy chain's federal tax identification number, if the individual retail pharmacy's tax ID# is not available.)	3767	The Pharmacy Tax ID must be 9 digits.
PC	PC019	Pharmacy Tax ID Number	Federal taxpayer's identification number. (Please provide the pharmacy chain's federal tax identification number, if the individual retail pharmacy's tax ID# is not available.)	3909	Pharmacy Tax ID Number must be in integer (no decimal points) format, cannot be zero and cannot be negative.
PC	PC020	Pharmacy Name	Name of pharmacy	2252	Pharmacy Name is required.
PC	PC021	National Pharmacy ID Number	Required if National PV ID is mandated for use under HIPAA	2253	National Pharmacy ID Number is required.
PC	PC021	National Pharmacy ID Number	Required if National PV ID is mandated for use under HIPAA	3768	The National Pharmacy ID Number must be 10 digits.
PC	PC021	National Pharmacy ID Number	Required if National PV ID is mandated for use under HIPAA	2050	NULL
PC	PC022	Pharmacy Location City	City name of pharmacy - preferably pharmacy location	2254	Pharmacy Location City is required.
PC	PC023	Pharmacy Location State	As defined by the US Postal Service	2255	Pharmacy Location State is required.
PC	PC023	Pharmacy Location State	As defined by the US Postal Service	3835	The Pharmacy Location State must be within the valid domain of values.
PC	PC024	Pharmacy ZIP Code	ZIP Code of pharmacy - may include non-US codes. Do not include dash	3836	The Pharmacy Zip Code must be within the valid domain of values.
PC	PC024	Pharmacy ZIP Code	ZIP Code of pharmacy - may include non-US codes. Do not include dash	2256	Pharmacy ZIP Code is required.
PC	PC024A	Pharmacy Country Code	Country Code of pharmacy	2257	Pharmacy Country Code is required.
PC	PC024A	Pharmacy Country Code	Country Code of pharmacy	3837	The Pharmacy Country Code must be within the valid domain of values.
PC	PC025	Claim Status	See tlkpClaimStatus	1984	Claim Status must be within the valid domain of values.
PC	PC025	Claim Status	See tlkpClaimStatus	2630	Claim Status must be in integer (no decimal points) format .
PC	PC025	Claim Status	See tlkpClaimStatus	2258	Claim Status is required.
PC	PC026	Drug Code	NDC Code	2259	Drug Code is required.
PC	PC026	Drug Code	NDC Code	1985	Drug Code must be within the valid domain of values.

File Type	Element	Element Name	Element Description	Edit ID	Message
PC	PC027	Drug Name	Text name of drug	2260	Drug Name is required.
PC	PC028	New Prescription or Refill	00 = new prescription, else number of refill	2261	New Prescription or Refill is required.
PC	PC028	New Prescription or Refill	00 = new prescription, else number of refill	2631	New Prescription or Refill must be in integer (no decimal points) format and cannot be negative.
PC	PC029	Generic Drug Indicator	N No, branded drug, Y Yes, generic Drug	2262	Generic Drug Indicator is required.
PC	PC029	Generic Drug Indicator	N No, branded drug, Y Yes, generic Drug	1987	Generic Drug Indicator must be within the valid domain of values.
PC	PC030	Dispense as Written Code	See tlkpDispenseAsWritten	1988	Dispense as Written Code must be within the valid domain of values.
PC	PC030	Dispense as Written Code	See tlkpDispenseAsWritten	2263	Dispense as Written Code is required.
PC	PC030	Dispense as Written Code	See tlkpDispenseAsWritten	2632	Dispense as Written Code must be in integer (no decimal points) format .
PC	PC031	Compound Drug Indicator	See tlkpCompoundDrug	2264	Compound Drug Indicator is required.
PC	PC031	Compound Drug Indicator	See tlkpCompoundDrug	1989	Compound Drug Indicator must be within the valid domain of values.
PC	PC032	Date Prescription Filled	CCYYMMDD	3799	The Date Prescription filled cannot be greater than the Date Prescription written.
PC	PC032	Date Prescription Filled	CCYYMMDD	2265	Date Prescription Filled is required.
PC	PC032	Date Prescription Filled	CCYYMMDD	2575	Date Prescription Filled must be in date format (YYYYMMDD).
PC	PC033	Quantity Dispensed	Number of metric units of medication dispensed	2633	Quantity Dispensed must be in integer (no decimal points) format , cannot be negative and cannot be zero.
PC	PC033	Quantity Dispensed	Number of metric units of medication dispensed	2266	Quantity Dispensed is required.
PC	PC034	Days Supply	Estimated number of days the prescription will last	2267	Days Supply is required.
PC	PC034	Days Supply	Estimated number of days the prescription will last	2634	Days Supply must be in integer (no decimal points) format , cannot be negative and cannot be zero.
PC	PC035	Charge Amount	Do not code decimal point	2268	Charge Amount is required.
PC	PC035	Charge Amount	Do not code decimal point	2635	Charge Amount must be in integer (no decimal points) format and cannot be zero.

File Type	Element	Element Name	Element Description	Edit ID	Message
PC	PC036	Paid Amount	Includes all health plan payments and excludes all member payments. Do not include decimal points.	2636	Paid Amount must be in integer (no decimal points) format and cannot be negative.
PC	PC036	Paid Amount	Includes all health plan payments and excludes all member payments. Do not include decimal points.	3865	The Paid Amount is required when Claim Status (PC025) = 01, 02, 03, 19, 20, 21.
PC	PC037	Ingredient Cost/List Price	Ingredient Cost/List Price of the drug dispensed.	2270	Ingredient Cost/List Price is required.
PC	PC037	Ingredient Cost/List Price	Ingredient Cost/List Price of the drug dispensed.	2637	Ingredient Cost/List Price must be in integer (no decimal points) format and cannot be zero.
PC	PC038	Postage Amount Claimed	Do not code decimal point	2271	Postage Amount Claimed is required.
PC	PC038	Postage Amount Claimed	Do not code decimal point	2638	Postage Amount Claimed must be in integer (no decimal points) format and cannot be negative.
PC	PC039	Dispensing Fee	Do not code decimal point	2272	Dispensing Fee is required.
PC	PC039	Dispensing Fee	Do not code decimal point	2639	Dispensing Fee must be in integer (no decimal points) format and cannot be negative.
PC	PC040	Copay Amount	The preset, fixed dollar amount for which the individual is responsible. Do not include decimal point.	2273	Copay Amount is required.
PC	PC040	Copay Amount	The preset, fixed dollar amount for which the individual is responsible. Do not include decimal point.	2640	Copay Amount must be in integer (no decimal points) format and cannot be negative.
PC	PC041	Coinsurance Amount	Do not code decimal point	2274	Coinsurance Amount is required.
PC	PC041	Coinsurance Amount	Do not code decimal point	2641	Coinsurance Amount must be in integer (no decimal points) format and cannot be negative.
PC	PC042	Deductible Amount	Do not code decimal point	2275	Deductible Amount is required.
PC	PC042	Deductible Amount	Do not code decimal point	2642	Deductible Amount must be in integer (no decimal points) format and cannot be negative.
PC	PC043	Prescribing PVID	The number of the prescribing PV which links to this PV in the PV file, on field PV002. Fields PC044-PC055 are optional if the value in this field links to a value in PV002.	2276	Prescribing PVID is required.
PC	PC044	Prescribing Physician First Name	Physician first name (Optional if PC047 is filled with DEA number).	3879	The Prescribing Physician First Name is required when Prescribing PVID (PC043) is empty.
PC	PC045	Prescribing Physician Middle Name	Physician middle name or initial (Optional if PC047 is filled with DEA number).	3880	The Prescribing Physician Middle Name is required when Prescribing PVID (PC043) is empty.

File Type	Element	Element Name	Element Description	Edit ID	Message
PC	PC046	Prescribing Physician Last Name	Physician last name (Optional if PC047 is filled with DEA number; required if PC047 is blank or is filled with NPI number).	3881	The Prescribing Physician Last Name is required when Prescribing PVID (PC043) is empty.
PC	PC047	Prescribing Physician DEA Number	DEA number for prescribing physician.	3882	The Prescribing Physician DEA Number is required when Prescribing PVID (PC043) is empty.
PC	PC047	Prescribing Physician DEA Number	DEA number for prescribing physician.	3696	Prescribing Physician DEA number must have alpha characters in position 1 and 2 and must have numeric characters in position 3-9.
PC	PC048	Prescribing Physician NPI	PI number for prescribing physician.	3883	The Prescribing Physician NPI is required when Prescribing PVID (PC043) is empty.
PC	PC048	Prescribing Physician NPI	PI number for prescribing physician.	3699	Prescribing Physician NPI must be 10 characters and numeric.
PC	PC049	Prescribing Physician Plan Number	Prescribing Physician Plan Number	3884	The Prescribing Physician Plan Number is required when Prescribing PVID (PC043) is empty.
PC	PC050	Prescribing Physician License Number	Prescribing Physician License Number	3885	The Prescribing Physician License Number is required when Prescribing PVID (PC043) is empty.
PC	PC051	Prescribing Physician Street Address	Prescribing Physician Street Address	3886	The Prescribing Physician Street Address is required when Prescribing PVID (PC043) is empty.
PC	PC052	Prescribing Physician Street Address 2	Prescribing Physician Street Address 2	3887	The Prescribing Physician Street Address 2 is required when Prescribing PVID (PC043) is empty.
PC	PC052	Prescribing Physician Street Address 2	Prescribing Physician Street Address 2	3820	The Prescribing Physician Street Address 2 is required when the Prescribing Physician Street Address (PC051) is not present.
PC	PC053	Prescribing Physician City	Prescribing Physician City	3888	The Prescribing Physician City is required when Prescribing PVID (PC043) is empty.
PC	PC054	Prescribing Physician State	Prescribing Physician State	3889	The Prescribing Physician State is required when Prescribing PVID (PC043) is empty.
PC	PC054	Prescribing Physician State	Prescribing Physician State	3838	The Prescribing Physician State must be within the valid domain of values.
PC	PC055	Prescribing Physician Zip	Prescribing Physician Zip	3839	The Prescribing Physician Zip must be within the valid domain of values.
PC	PC055	Prescribing Physician Zip	Prescribing Physician Zip	3890	The Prescribing Physician Zip is required when Prescribing PVID (PC043) is empty.
PC	PC056	PR ID Number	Must correspond to the PR file.	2289	PR ID Number is required.
PC	PC057	Mail Order Pharmacy	Mail Order pharmacy = 1 all other =0.	2290	Mail Order Pharmacy is required.
PC	PC057	Mail Order Pharmacy	Mail Order pharmacy = 1 all other =0.	2677	Mail Order Pharmacy must be within the valid domain of values.

File Type	Element	Element Name	Element Description	Edit ID	Message
PC	PC058	Script Number	Script Number	2291	Script Number is required.
PC	PC059	Recipient PCP ID	Recipient PCP ID	2292	Recipient PCP ID is required.
PC	PC060	Single/Multiple Source Indicator	Values 1 = Single Source or 2 = Multi Source.	2678	Single/Multiple Source Indicator must be within the valid domain of values.
PC	PC060	Single/Multiple Source Indicator	Values 1 = Single Source or 2 = Multi Source.	2293	Single/Multiple Source Indicator is required.
PC	PC061	Member Street Address	Street address of member.	2294	Member Street Address is required.
PC	PC062	Billing PV Tax ID Number	Billing PV Tax ID Number	2295	Billing PV Tax ID Number is required.
PC	PC062	Billing PV Tax ID Number	Billing PV Tax ID Number	3910	Billing PV Tax ID Number must be in integer (no decimal points) format, cannot be zero and cannot be negative.
PC	PC062	Billing PV Tax ID Number	Billing PV Tax ID Number	3770	The Billing PV Tax ID Number must be 9 digits.
PC	PC063	Paid Date	YYYYMMDD	3690	Paid must be between the Period Begin and Period End Dates on the Transmittal Record.
PC	PC063	Paid Date	YYYYMMDD	2296	Paid Date is required.
PC	PC063	Paid Date	YYYYMMDD	2576	Paid Date must be in date format (YYYYMMDD) and cannot be a future date.
PC	PC064	Date Prescription Written	Date Prescription Written	2297	Date Prescription Written is required.
PC	PC064	Date Prescription Written	Date Prescription Written	2577	Date Prescription Written must be in date format (YYYYMMDD) and cannot be a future date.
PC	PC064	Date Prescription Written	Date Prescription Written	3703	Date Prescription Written cannot be greater than the Paid Date and cannot be greater than the Date Prescription Filled.
PC	PC065	Coordination of Benefits/TPL Liability Amount	Coordination of Benefits/TPL Liability Amount	2643	Coordination of Benefits/TPL Liability Amount must be in integer (no decimal points) format and cannot be zero.
PC	PC065	Coordination of Benefits/TPL Liability Amount	Coordination of Benefits/TPL Liability Amount	2298	Coordination of Benefits/TPL Liability Amount is required when PC025 is 19, 20 or 21.
PC	PC066	Other Insurance Paid Amount	Other Insurance Paid Amount	2299	Other Insurance Paid Amount is required when PC025 is 02, 03, 20 or 21.
PC	PC066	Other Insurance Paid Amount	Other Insurance Paid Amount	2644	Other Insurance Paid Amount must be in integer (no decimal points) format .

File Type	Element	Element Name	Element Description	Edit ID	Message
PC	PC067	Medicare Paid Amount	Medicare Paid Amount	2645	Medicare Paid Amount must be in integer (no decimal points) format .
PC	PC068	Allowed Amount	Allowed Amount	2301	Allowed Amount is required when PC025 is 04 or 22.
PC	PC068	Allowed Amount	Allowed Amount	2646	Allowed Amount must be in integer (no decimal points) format and cannot be zero.
PC	PC069	Member Self Pay Amount	Amount member paid if they chose to pay out of pocket instead of using pharmacy benefit copay structure.	2647	Member Self Pay Amount must be in integer (no decimal points) format .
PC	PC070	Rebate Indicator	Determines if the drug is eligible for a rebate.	2303	Rebate Indicator is required.
PC	PC070	Rebate Indicator	Determines if the drug is eligible for a rebate.	2080	Rebate Indicator must be within the valid domain of values.
PC	PC071	State Sales Tax	The dollar amount of any applicable sales tax.	2648	State Sales Tax must be in integer (no decimal points) format .
PC	PC072	Delegated Benefit Administrator Organization ID	If the record is sourced from a delegated benefit administrator, this field contains the DHCFP assigned organization ID for the delegated benefit administrator. Contact DHCFP for the appropriate value. Report null values if not applicable.	3915	Delegated Benefit Administrator Organization ID must be in integer (no decimal points) format.
PC	PC072	Delegated Benefit Administrator Organization ID	If the record is sourced from a delegated benefit administrator, this field contains the DHCFP assigned organization ID for the delegated benefit administrator. Contact DHCFP for the appropriate value. Report null values if not applicable.	3862	When present, the DelegatedBenefitAdministratorOrganizationID must be a valid orgid.
PC	PC073	Formulary Code	Determines if drug is on the formulary, with a Y or N.	2729	Formulary Code must be within the valid domain of values.
PC	PC073	Formulary Code	Determines if drug is on the formulary, with a Y or N.	2306	Formulary Code is required.
PC	PC074	Route of Administration	Indicates how drug is administered.	2307	Route of Administration is required.
PC	PC074	Route of Administration	Indicates how drug is administered.	2730	Route of Administration must be within the valid domain of values.
PC	PC075	Drug Unit of Measure	Drug Unit of Measure	2679	Drug Unit of Measure must be within the valid domain of values.
PC	PC075	Drug Unit of Measure	Drug Unit of Measure	2308	Drug Unit of Measure is required.
PC	PC101	Subscriber Last Name	Subscriber Last Name	2309	Subscriber Last Name is required.
PC	PC102	Subscriber First Name	Subscriber First Name	2310	Subscriber First Name is required.
PC	PC104	Member Last Name	Member Last Name	2312	Member Last Name is required.
PC	PC105	Member First Name	Member First Name	2313	Member First Name is required.

File Type	Element	Element Name	Element Description	Edit ID	Message
PC	PC107	Carrier Specific UniqueID	This is the number the carrier uses internally to uniquely identify the member.	2315	Carrier Specific UniqueID is required.
PC	PC108	Carrier Specific Unique Subscriber ID	This is the number the carrier uses internally to uniquely identify the subscriber.	2316	Carrier Specific Unique Subscriber ID is required.
PC	PC109	Member Street Address 2	Address of member, which may include apartment number or suite, or other secondary information besides the street.	3821	The Member Street Address 2 is required when the Member Street Address (PC061) is not present.
PC	PC110	Claim Line Type	Code Indicating Type of Record. See lookup table for values (Original, Void, Replacement, Back Out, Amendment)	2680	Claim Line Type must be within the valid domain of values.
PC	PC110	Claim Line Type	Code Indicating Type of Record. See lookup table for values (Original, Void, Replacement, Back Out, Amendment)	2318	Claim Line Type is required.
PC	PC899	Record Type	PC	2320	Record Type is required.
PC	PC899	Record Type	PC	3724	RecordType must match the RecordType in the header and the trailer.
PR	PR001	PR ID number	PR Identification Number	1946	The Payer Field within each record of the file must match the Payer Field on the Header Record.
PR	PR001	PR ID number	PR Identification Number	2550	PR ID number is required.
PR	PR002	PR Name	Carrier defined PR Name	2551	PR Name is required.
PR	PR003	Carrier License Type	Carrier License Type	2552	Carrier License Type is required.
PR	PR003	Carrier License Type	Carrier License Type	2053	Carrier License Type must be within the valid domain of values.
PR	PR004	PR Line of Business Model	The Line of Business / Insurance Model the PR relates to.	2062	PR Line of Business Model must be within the valid domain of values.
PR	PR004	PR Line of Business Model	The Line of Business / Insurance Model the PR relates to.	2553	PR Line of Business Model is required.
PR	PR005	Insurance Plan Market	Insurance Plan Market Code	2554	Insurance Plan Market is required.
PR	PR005	Insurance Plan Market	Insurance Plan Market Code	2064	Insurance Plan Market must be within the valid domain of values.
PR	PR006	PR Benefit Type	Indicates combinations of offerings.	2065	PR Benefit Type must be within the valid domain of values.
PR	PR006	PR Benefit Type	Indicates combinations of offerings.	2555	PR Benefit Type is required.
PR	PR006	PR Benefit Type	Indicates combinations of offerings.	2676	PR Benefit Type must be in integer (no decimal points) format .
PR	PR007	Other PR Benefit Description	Benefit Description	3831	Other PR Benefit Description is required when PR006 = 0.

File Type	Element	Element Name	Element Description	Edit ID	Message
PR	PR008	Risk Type	Indicates if the PR was an at-risk PR or self-insured.	3832	Risk Type must be within the valid domain of values.
PR	PR008	Risk Type	Indicates if the PR was an at-risk PR or self-insured.	2557	Risk Type is required.
PR	PR009	PR Start Date	PR Start Date	2558	PR Start Date is required.
PR	PR009	PR Start Date	PR Start Date	2597	PR Start Date must be in date format (YYYYMMDD) and cannot be a future date.
PR	PR010	PR End Date	Last date on which members could be enrolled in this PR	2598	PR End Date must be in date format (YYYYMMDD).
PR	PR011	PR Active Flag	Indicator to further refine activity status	2560	PR Active Flag is required.
PR	PR011	PR Active Flag	Indicator to further refine activity status	2681	PR Active Flag must be within the valid domain of values.
PR	PR011	PR Active Flag	Indicator to further refine activity status	3704	PR End Date must be > PR Start Date if Active Flag = 2
PR	PR012	Annual Per Person Deductible Code	Per Person Deductible bandwidth reporting	2682	Annual Per Person Deductible Code must be within the valid domain of values.
PR	PR012	Annual Per Person Deductible Code	Per Person Deductible bandwidth reporting	2561	Annual Per Person Deductible Code is required.
PR	PR013	Annual Per Family Deductible Code	Per Family Deductible bandwidth reporting	2562	Annual Per Family Deductible Code is required.
PR	PR013	Annual Per Family Deductible Code	Per Family Deductible bandwidth reporting	2683	Annual Per Family Deductible Code must be within the valid domain of values.
PR	PR014	Coordinated Care model	Indicates if a patient's care is clinically coordinated or managed.	2684	Coordinated Care model must be within the valid domain of values.
PR	PR014	Coordinated Care model	Indicates if a patient's care is clinically coordinated or managed.	2563	Coordinated Care model is required.
PR	PR899	Record Type	PR	2564	Record Type is required.
PR	PR899	Record Type	PR	3726	RecordType must match the RecordType in the header and the trailer.
PV	PV001	Payer	CMS National Plan ID	1945	The Payer Field within each record of the file must match the Payer Field on the Header Record.
PV	PV001	Payer	CMS National Plan ID	2485	Payer is required.
PV	PV002	Plan PV ID	Plan PV ID.	2486	Plan PV ID is required.
PV	PV003	Tax Id	Federal Tax ID - no hyphens.	2487	Tax Id is required.
PV	PV003	Tax Id	Federal Tax ID - no hyphens.	3705	Tax ID must be in proper tax ID format and have no hyphens
PV	PV003	Tax Id	Federal Tax ID - no hyphens.	3911	Tax Id must be in integer (no decimal points) format, cannot be zero and cannot be negative.

File Type	Element	Element Name	Element Description	Edit ID	Message
PV	PV004	UPIN Id	UPIN Number. If not available, default to null. Do not use zeros.	3822	The UPIN ID is required when the PVIDCode (PV034) equals 1 and (PV036) Medicare ID is not blank.
PV	PV005	DEA Id	Drug Enforcement Agency number.. If not available, default to null. Do not use zeros.	3823	The DEA ID is required when the PVIDCode (PV034) equals 1.
PV	PV005	DEA Id	Drug Enforcement Agency number.. If not available, default to null. Do not use zeros.	3706	DEA ID may not have letters V-Z in first position, must have letters in the first 2 positions and must have numbers in positions 3 - 9.
PV	PV008	Last Name	Last name of PV or full facility name. Punctuation may be included. If the facility name is present, this field is ignored.	3800	The Last Name is required when the PVID Code (PV034) = 1.
PV	PV009	First Name	First name of PV. Punctuation may be included.. If the facility name is present, this field is ignored.	3801	The First Name is required when the PVID Code (PV034) = 1.
PV	PV010	Middle Initial	Middle initial of PV. If the facility name is present, this field is ignored.	3802	The Middle Initial is required when the PVID Code (PV034) = 1.
PV	PV012	Entity Name	Group / Facility name	3803	The Entity Name is required when the PVID Code (PV034) = 2.
PV	PV013	Entity Code	PV facility code	2066	Entity Code must be within the valid domain of values.
PV	PV013	Entity Code	PV facility code	3876	Entity Code is required when PV034 = 2,3,4,5,6,7,0.
PV	PV014	Gender Code	Gender of PV.. if available, this may be used to link PVs together. If not available, default to null.	2067	Gender Code must be within the valid domain of values.
PV	PV014	Gender Code	Gender of PV.. if available, this may be used to link PVs together. If not available, default to null.	3871	The Gender Code is required when PV ID Code (PV034) = 1.
PV	PV015	DOB Date	Date of birth of PV. 20050501(yyyymmdd). YYYYMMDD is the preferred date format. If not available or applicable, default to null value.	3824	The Date of Birth is required when the PVIDCode (PV034) equals 1.
PV	PV015	DOB Date	Date of birth of PV. 20050501(yyyymmdd). YYYYMMDD is the preferred date format. If not available or applicable, default to null value.	2592	DOB Date must be in date format (YYYYMMDD) and cannot be a future date.
PV	PV016	Street Address1 Name	Street address where PV sees plan members. Brick & mortar. If only mailing address is available, please send the mailing address in this field in addition to putting it in the mailing address field.	2500	Street Address1 Name is required.
PV	PV017	Street Address2 Name	Street address where services were rendered. brick & mortar. Optional	3872	The Street Address2 Name is required when Street Address1 Name (PV016) is missing.
PV	PV018	City Name	City where PV sees plan members. If only mailing address is available, please send the mailing address in this field in addition to putting it in the mailing address field.	2502	City Name is required.

File Type	Element	Element Name	Element Description	Edit ID	Message
PV	PV019	State Code	State. If only mailing address is available, please send the mailing address in this field in addition to putting it in the mailing address field. If populated, this should be a valid USPS state code.	3874	The State Code is required when the Country Code (PV020) is USA.
PV	PV019	State Code	State. If only mailing address is available, please send the mailing address in this field in addition to putting it in the mailing address field. If populated, this should be a valid USPS state code.	3840	The State Code must be within the valid domain of values.
PV	PV020	Country Code	Country Code of the PV	3841	The Country Code must be within the valid domain of values.
PV	PV020	Country Code	Country Code of the PV	2504	Country Code is required.
PV	PV021	Zip Code	Zip where PV sees and treats plan members. If only mailing address is available, please send the mailing address in this field in addition to putting it in the mailing address field.	2505	Zip Code is required.
PV	PV022	Taxonomy	Taxonomy code	3804	The Taxonomy is required when the PVIDCode (PV034) equals 0,1,2,3,4, or 5.
PV	PV022	Taxonomy	Taxonomy code	3727	Taxonomy must be within the valid domain of values.
PV	PV023	Mailing Street Address1 Name	Mailing address	2507	Mailing Street Address1 Name is required.
PV	PV024	Mailing Street Address2 Name	Mailing address	3873	The Mailing Street Address2 Name is required when Mailing Street Address1 Name (PV023) is missing.
PV	PV025	Mailing City Name	Mailing address	2509	Mailing City Name is required.
PV	PV026	Mailing State Code	Mailing address	3875	The Mailing State Code is required when the Mailing Country Code (PV027) is USA.
PV	PV026	Mailing State Code	Mailing address	3769	The Mailing State Code must be within the valid domain of values.
PV	PV027	Mailing Country Code	Mailing address	3842	The Mailing Country Code must be within the valid domain of values.
PV	PV027	Mailing Country Code	Mailing address	2511	Mailing Country Code is required.
PV	PV028	Mailing Zip Code	Mailing address	2512	Mailing Zip Code is required.

File Type	Element	Element Name	Element Description	Edit ID	Message
PV	PV029	PV Type Code	Reference tables required - Provide a cross-reference table for any values used in this field.. This is a required field that distinguishes clinicians, facilities, and other. Clinicians are physicians and other practitioners who can perform an E&M service (thereby start an episode). Facilities can sometimes start episodes (i.e. patient goes to ER at onset of symptoms). PVs classified as other never start episodes.	2513	PV Type Code is required.
PV	PV030	Primary Specialty Code	Reference tables required: provide a cross-reference table for any values used in this field.. If the Plan cannot determine which specialty is primary, then populate this field with the PVs specialty for purposes of assigning cost and quality measures. For non-physicians, set this to a value that indicates that the PV is a hospital, or facility or has no specialty.	3805	The Primary Specialty Code is required when the PVIDCode (PV034) equals 0,1,2,3,4, or 5.
PV	PV030	Primary Specialty Code	Reference tables required: provide a cross-reference table for any values used in this field.. If the Plan cannot determine which specialty is primary, then populate this field with the PVs specialty for purposes of assigning cost and quality measures. For non-physicians, set this to a value that indicates that the PV is a hospital, or facility or has no specialty.	2072	Primary Specialty Code must be within the valid domain of values.
PV	PV034	PV ID Code	PV Identification Code	2074	PV ID Code must be within the valid domain of values.
PV	PV034	PV ID Code	PV Identification Code	2518	PV ID Code is required.
PV	PV035	SSN Id	Social Security Number of the PV. No hyphens. If not available, set to null.	3712	SSN ID is required when PV ID Code (PV034) = 1 and when present SSN ID must be in valid SSN format.
PV	PV035	SSN Id	Social Security Number of the PV. No hyphens. If not available, set to null.	3912	SSN Id must be in integer (no decimal points) format, cannot be zero and cannot be negative.
PV	PV036	Medicare Id	Medicare ID of the PV. If not available, set to null.	3806	The Medicare is required when the PVIDCode (PV034) equals 0,1,2,3,4, or 5 and the UPINID (PV004) is not null.
PV	PV037	Begin Date	Date PV becomes eligible to perform services for plan members/insured's. YYYYMMDD	3713	Begin Date cannot be future date
PV	PV037	Begin Date	Date PV becomes eligible to perform services for plan members/insured's. YYYYMMDD	2593	Begin Date must be in date format (YYYYMMDD) and cannot be a future date.
PV	PV038	End Date	Date PV is no longer eligible to perform services for plan members/insureds. YYYYMMDD	2594	End Date must be in date format (YYYYMMDD).
PV	PV038	End Date	Date PV is no longer eligible to perform services for plan members/insureds. YYYYMMDD	3714	End Date must be after Begin Date

File Type	Element	Element Name	Element Description	Edit ID	Message
PV	PV039	National PV ID	For each clinician and organization.	3715	National PV ID must be ten numbers
PV	PV039	National PV ID	For each clinician and organization.	3807	The National PV ID is required when the PVIDCode (PV034) equals 0,1,2,3,4, or 5.
PV	PV039	National PV ID	For each clinician and organization.	3858	The National PVID must be within the valid domain of values.
PV	PV040	National PV2 ID	Optional NPI id if available.	3859	The National PV2ID must be within the valid domain of values.
PV	PV040	National PV2 ID	Optional NPI id if available.	3716	National PV2 ID must be ten numbers and is required when PV Type Code = 0, 1, 2, 3, 4 or 5.
PV	PV042	Secondary Specialty2 Code	see mapping notes for primary specialty above.	3808	The Secondary Specialty 2 Code is required when the PVIDCode (PV034) equals 0,1,2,3,4, or 5.
PV	PV042	Secondary Specialty2 Code	see mapping notes for primary specialty above.	3748	SecondarySpecialty2Code must be within the valid domain of values.
PV	PV043	Secondary Specialty3 Code	see mapping notes for primary specialty above.	3749	SecondarySpecialty3Code must be within the valid domain of values.
PV	PV044	Secondary Specialty4 Code	see mapping notes for primary specialty above.	3750	SecondarySpecialty4Code must be within the valid domain of values.
PV	PV045	P4P Flag	Pay-for-performance bonuses or year-end withhold returns based on performance. Supplemental file will be required Yes=1, No=0	2734	P4P Flag must be within the valid domain of values.
PV	PV045	P4P Flag	Pay-for-performance bonuses or year-end withhold returns based on performance. Supplemental file will be required Yes=1, No=0	2529	P4P Flag is required.
PV	PV046	NonClaimsFlag	Other payments not flowing through the claims system (such as risk sharing). Supplemental file will be required Yes=1, No=0	2530	NonClaimsFlag is required.
PV	PV046	NonClaimsFlag	Other payments not flowing through the claims system (such as risk sharing). Supplemental file will be required Yes=1, No=0	2735	NonClaimsFlag must be within the valid domain of values.
PV	PV047	Uses Electronic Medical Records	PV Uses EMR indicator	2736	Uses Electronic Medical Records must be within the valid domain of values.
PV	PV047	Uses Electronic Medical Records	PV Uses EMR indicator	2531	Uses Electronic Medical Records is required.
PV	PV048	EMR Vendor	Name of EMR vendor	3811	The EMR Vendor is required when Uses Electronic Medical Records (PV047) equals 1.
PV	PV049	Accepting New Patients	Accepting New Patients	2737	Accepting New Patients must be within the valid domain of values.

File Type	Element	Element Name	Element Description	Edit ID	Message
PV	PV049	Accepting New Patients	Accepting New Patients	2533	Accepting New Patients is required.
PV	PV050	Offers e-Visits	indicates if PV uses e-visit tools for well visits.	2534	Offers e-Visits is required.
PV	PV050	Offers e-Visits	indicates if PV uses e-visit tools for well visits.	2738	Offers e-Visits must be within the valid domain of values.
PV	PV052	Has multiple offices	Indicates if PV has multiple offices	2739	Has multiple offices must be within the valid domain of values.
PV	PV052	Has multiple offices	Indicates if PV has multiple offices	2536	Has multiple offices is required.
PV	PV055	PCP Flag	Indicates if the PV is a PCP.	2539	PCP Flag is required.
PV	PV055	PCP Flag	Indicates if the PV is a PCP.	2740	PCP Flag must be within the valid domain of values.
PV	PV056	PV Affiliation	Indicates the parent entity/group that the PV belongs to	3717	PV Affiliation value must match a value in PV002 for a different record or the same record
PV	PV056	PV Affiliation	Indicates the parent entity/group that the PV belongs to	2540	PV Affiliation is required.
PV	PV057	PV Telephone	PV Telephone	2541	PV Telephone is required.
PV	PV057	PV Telephone	PV Telephone	3718	PV telephone must be 10 characters with no hyphens
PV	PV058	Delegated PV Record Flag	PV Record Source Indicator	2741	Delegated PV Record Flag must be within the valid domain of values.
PV	PV058	Delegated PV Record Flag	PV Record Source Indicator	2542	Delegated PV Record Flag is required.
PV	PV060	Office Type	indicates if the office is a facility, or doctor’s office, or clinic, or walk in or lab	2079	Office Type must be within the valid domain of values.
PV	PV060	Office Type	indicates if the office is a facility, or doctor’s office, or clinic, or walk in or lab	2544	Office Type is required.
PV	PV061	Prescribing PV	Indicates if the PV has prescribing privileges	2742	Prescribing PV must be within the valid domain of values.
PV	PV061	Prescribing PV	Indicates if the PV has prescribing privileges	2545	Prescribing PV is required.
PV	PV062	PV Affiliation Start Date	Indicates start date of PVs relationship with parent entity/group	3719	PV Affiliation Start Date cannot be a future date
PV	PV062	PV Affiliation Start Date	Indicates start date of PVs relationship with parent entity/group	2546	PV Affiliation Start Date is required.
PV	PV062	PV Affiliation Start Date	Indicates start date of PVs relationship with parent entity/group	2595	PV Affiliation Start Date must be in date format (YYYYMMDD) and cannot be a future date.
PV	PV063	PV Affiliation End Date	Indicates end date of PVs relationship with parent entity/group	2596	PV Affiliation End Date must be in date format (YYYYMMDD).

File Type	Element	Element Name	Element Description	Edit ID	Message
PV	PV063	PV Affiliation End Date	Indicates end date of PVs relationship with parent entity/group	3720	PV Affiliation End Date must be greater than PV Affiliation Start Date
PV	PV064	PPO Indicator	Indicates if the PV is a contracted network PV	2743	PPO Indicator must be within the valid domain of values.
PV	PV064	PPO Indicator	Indicates if the PV is a contracted network PV	2548	PPO Indicator is required.
PV	PV899	Record Type	PV [PV file].	2549	Record Type is required.
PV	PV899	Record Type	PV [PV file].	3721	Record Type must match the Record Type on the Header and the Record Type on the Trailer
TR	TR002	Payer	Payer submitting payments/Council Submitter Code	210	The Payer Field on the Trailer Record must be a valid DHCFP assigned OrgID.
TR	TR005	Period Beginning Date	CCYYMM, Beginning of paid period for claims, Beginning of month covered for eligibility	207	The Period Beginning Date on the Trailer Record must correspond with the Year and Quarter entered on the Transmittal Sheet.
TR	TR006	Period Ending Date	CCYYMM, End of paid period for claims, End of month covered for eligibility	208	The Period Ending Date on the Trailer Record must correspond with the Year and Quarter entered on the Transmittal Sheet.
FLE		File Level Edits		195	The first record in the file must be a Header Record with a Record Type of HD.
FLE				196	The length of the record exceeds the maximum possible length.
FLE				197	Each line in the Record must be of the same file type.
FLE				198	The last line in the file must be a Trailer Record and have a Record type of TR.
FLE				215	Each line in the Record must contain the correct number of delimited fields.
FLE				217	The Record Type within the detail record of the file does not match HD004 (Type of File) on the Header Record.

Edit Information for Grouping the All Payer Claims Data

Intake edits were performed on all six file types. A complete list of the edits can be found in this document under the EDITS section. Below is an overview of the edits applied to the fields commonly used by Grouper software. The breakout outlines the number of errors found for each edit within each year. Review of the data prior to grouping for these issues may be warranted.

Edit ID	Number of Errors	Submission Year	Message	Data Element	Element Name	Threshold	Field Level
1958	17,701	2008	Insurance Type Code/Product must be within the valid domain of values.	MC003	Insurance Type Code/Product	92	C
1958	20,898	2009	Insurance Type Code/Product must be within the valid domain of values.	MC003	Insurance Type Code/Product	92	C
1958	6,280,863	2010	Insurance Type Code/Product must be within the valid domain of values.	MC003	Insurance Type Code/Product	92	C
2091	95,733	2008	Insurance Type Code/Product is required.	MC003	Insurance Type Code/Product	92	C
2091	181,594	2009	Insurance Type Code/Product is required.	MC003	Insurance Type Code/Product	92	C
2091	242,815	2010	Insurance Type Code/Product is required.	MC003	Insurance Type Code/Product	92	C
2092	3	2011	Payer Claim Control Number is required.	MC004	Payer Claim Control Number	100	A0
1960	NULL	NULL	Member Gender must be within the valid domain of values.	MC012	Member Gender	98	B
2102	194	2008	Member Date of Birth is required.	MC013	Member Date of Birth	98	B
2102	343	2009	Member Date of Birth is required.	MC013	Member Date of Birth	98	B
2102	462	2010	Member Date of Birth is required.	MC013	Member Date of Birth	98	B
2565	30	2008	Member Date of Birth must be in date format (YYYYMMDD) and cannot be a future date.	MC013	Member Date of Birth	98	B
2565	49	2009	Member Date of Birth must be in date format (YYYYMMDD) and cannot be a future date.	MC013	Member Date of Birth	98	B
2565	25	2010	Member Date of Birth must be in date format (YYYYMMDD) and cannot be a future date.	MC013	Member Date of Birth	98	B

Edit ID	Number of Errors	Submission Year	Message	Data Element	Element Name	Threshold	Field Level
3848	633	2008	The Member Date of Birth cannot be after the date of service.	MC013	Member Date of Birth	98	B
3848	1,085	2009	The Member Date of Birth cannot be after the date of service.	MC013	Member Date of Birth	98	B
3848	690	2010	The Member Date of Birth cannot be after the date of service.	MC013	Member Date of Birth	98	B
2567	73,503	2008	Admission Date must be in date format (YYYYMMDD) and cannot be a future date.	MC018	Admission Date	98	A1
2567	145	2009	Admission Date must be in date format (YYYYMMDD) and cannot be a future date.	MC018	Admission Date	98	A1
2567	35	2010	Admission Date must be in date format (YYYYMMDD) and cannot be a future date.	MC018	Admission Date	98	A1
3760	138,365	2008	Admission Date is required when Type of Bill on Facility Claims (MC036) = 011x, 018x, 021x, 028x, 041x, 065x, 066x, 084x, 086x ,089x or Type of Claim = 002, must be in CCYYMMDD format and cannot be greater than the Discharge Date (MC069).	MC018	Admission Date	98	A1
3760	15,557	2009	Admission Date is required when Type of Bill on Facility Claims (MC036) = 011x, 018x, 021x, 028x, 041x, 065x, 066x, 084x, 086x ,089x or Type of Claim = 002, must be in CCYYMMDD format and cannot be greater than the Discharge Date (MC069).	MC018	Admission Date	98	A1
3760	31,002	2010	Admission Date is required when Type of Bill on Facility Claims (MC036) = 011x, 018x, 021x, 028x, 041x, 065x, 066x, 084x, 086x ,089x or Type of Claim = 002, must be in CCYYMMDD format and cannot be greater than the Discharge Date (MC069).	MC018	Admission Date	98	A1
3745	9,602	2008	Admission Source must be within the valid domain of values.	MC021	Admission Source	80	A1
3745	9,598	2009	Admission Source must be within the valid domain of values.	MC021	Admission Source	80	A1
3745	12,025	2010	Admission Source must be within the valid domain of values.	MC021	Admission Source	80	A1
3772	838,860	2008	The Admission Source is required when Type of Bill on Facility Claims equals 011x, 018x, 021x, 028x, 041x, 065x, 066x, 084x, 086x, or 089x and Type of Claim = 002.	MC021	Admission Source	80	A1
3772	713,334	2009	The Admission Source is required when Type of Bill on Facility Claims equals 011x, 018x, 021x, 028x, 041x, 065x, 066x, 084x, 086x, or 089x and Type of Claim = 002.	MC021	Admission Source	80	A1

Edit ID	Number of Errors	Submission Year	Message	Data Element	Element Name	Threshold	Field Level
3772	760,917	2010	The Admission Source is required when Type of Bill on Facility Claims equals 011x, 018x, 021x, 028x, 041x, 065x, 066x, 084x, 086x, or 089x and Type of Claim = 002.	MC021	Admission Source	80	A1
2605	36	2008	Discharge Status must be in integer (no decimal points) format .	MC023	Discharge Status	98	A1
2605	73	2009	Discharge Status must be in integer (no decimal points) format .	MC023	Discharge Status	98	A1
2605	282	2010	Discharge Status must be in integer (no decimal points) format .	MC023	Discharge Status	98	A1
3737	1,844,708	2008	DischargeStatus must be within the valid domain of values.	MC023	Discharge Status	98	A1
3737	2,393,111	2009	DischargeStatus must be within the valid domain of values.	MC023	Discharge Status	98	A1
3737	2,067,662	2010	DischargeStatus must be within the valid domain of values.	MC023	Discharge Status	98	A1
3849	162,025	2008	The Discharge Status is required when Type of Bill on Facility Claims equals 011x, 018x, 021x, 028x, 041x, 065x, 066x, 084x, 086x, or 089x and Type of Claim (MC094) = 002.	MC023	Discharge Status	98	A1
3849	38,636	2009	The Discharge Status is required when Type of Bill on Facility Claims equals 011x, 018x, 021x, 028x, 041x, 065x, 066x, 084x, 086x, or 089x and Type of Claim (MC094) = 002.	MC023	Discharge Status	98	A1
3849	40,221	2010	The Discharge Status is required when Type of Bill on Facility Claims equals 011x, 018x, 021x, 028x, 041x, 065x, 066x, 084x, 086x, or 089x and Type of Claim (MC094) = 002.	MC023	Discharge Status	98	A1
2121	21,355,710	2008	Service Provider Specialty is required.	MC032	Service Provider Specialty	98	B
2121	22,555,475	2009	Service Provider Specialty is required.	MC032	Service Provider Specialty	98	B
2121	24,219,107	2010	Service Provider Specialty is required.	MC032	Service Provider Specialty	98	B
3850	27,162,320	2008	The Service Provider Specialty must be within the valid domain of values.	MC032	Service Provider Specialty	98	B
3850	30,684,884	2009	The Service Provider Specialty must be within the valid domain of values.	MC032	Service Provider Specialty	98	B
3850	17,668,917	2010	The Service Provider Specialty must be within the valid domain of values.	MC032	Service Provider Specialty	98	B

Edit ID	Number of Errors	Submission Year	Message	Data Element	Element Name	Threshold	Field Level
2607	9	2008	Type of Bill – on Facility Claims must be in integer (no decimal points) format .	MC036	Type of Bill – on Facility Claims	90	A0
2607	4	2009	Type of Bill – on Facility Claims must be in integer (no decimal points) format .	MC036	Type of Bill – on Facility Claims	90	A0
2607	59	2010	Type of Bill – on Facility Claims must be in integer (no decimal points) format .	MC036	Type of Bill – on Facility Claims	90	A0
3741	6,097	2008	TypeofBillBillClassification must be within the valid domain of values.	MC036	Type of Bill – on Facility Claims	90	A0
3741	4,408	2009	TypeofBillBillClassification must be within the valid domain of values.	MC036	Type of Bill – on Facility Claims	90	A0
3741	8,809	2010	TypeofBillBillClassification must be within the valid domain of values.	MC036	Type of Bill – on Facility Claims	90	A0
3742	3,390	2008	TypeofBillFacilityType must be within the valid domain of values.	MC036	Type of Bill – on Facility Claims	90	A0
3742	1,896	2009	TypeofBillFacilityType must be within the valid domain of values.	MC036	Type of Bill – on Facility Claims	90	A0
3742	2,143	2010	TypeofBillFacilityType must be within the valid domain of values.	MC036	Type of Bill – on Facility Claims	90	A0
3773	1,326,473	2008	The Type of Bill on Facility Claims is required when Type of Claim (MC094) = 002.	MC036	Type of Bill – on Facility Claims	90	A0
3773	1,326,920	2009	The Type of Bill on Facility Claims is required when Type of Claim (MC094) = 002.	MC036	Type of Bill – on Facility Claims	90	A0
3773	945,993	2010	The Type of Bill on Facility Claims is required when Type of Claim (MC094) = 002.	MC036	Type of Bill – on Facility Claims	90	A0
3740	2,761	2008	Site of service must be within the valid domain of values.	MC037	Site of Service – on NSF/CMS 1500 Claims	65	A0
3740	97,473	2009	Site of service must be within the valid domain of values.	MC037	Site of Service – on NSF/CMS 1500 Claims	65	A0
3740	2,460,273	2010	Site of service must be within the valid domain of values.	MC037	Site of Service – on NSF/CMS 1500 Claims	65	A0

Edit ID	Number of Errors	Submission Year	Message	Data Element	Element Name	Threshold	Field Level
3774	549,503	2008	The Site of Service O nNSF CMS 1500 Claims is required when Type of Claim (MC094) = 001.	MC037	Site of Service – on NSF/CMS 1500 Claims	65	A0
3774	2,685,838	2009	The Site of Service O nNSF CMS 1500 Claims is required when Type of Claim (MC094) = 001.	MC037	Site of Service – on NSF/CMS 1500 Claims	65	A0
3774	6,606,224	2010	The Site of Service O nNSF CMS 1500 Claims is required when Type of Claim (MC094) = 001.	MC037	Site of Service – on NSF/CMS 1500 Claims	65	A0
1969	2,087	2008	Claim Status must be within the valid domain of values.	MC038	Claim Status	98	A0
1969	3,851	2009	Claim Status must be within the valid domain of values.	MC038	Claim Status	98	A0
1969	389,172	2010	Claim Status must be within the valid domain of values.	MC038	Claim Status	98	A0
2127	1,264,610	2008	Claim Status is required.	MC038	Claim Status	98	A0
2127	1,118,609	2009	Claim Status is required.	MC038	Claim Status	98	A0
2127	779,526	2010	Claim Status is required.	MC038	Claim Status	98	A0
2608	7	2008	Claim Status must be in integer (no decimal points) format .	MC038	Claim Status	98	A0
2608	2	2010	Claim Status must be in integer (no decimal points) format .	MC038	Claim Status	98	A0
3746	62,390	2008	Admitting Diagnosis must be within the valid domain of values.	MC039	Admitting Diagnosis	98	A1
3746	42,590	2009	Admitting Diagnosis must be within the valid domain of values.	MC039	Admitting Diagnosis	98	A1
3746	8,539	2010	Admitting Diagnosis must be within the valid domain of values.	MC039	Admitting Diagnosis	98	A1
3775	225,236	2008	The Admitting Diagnosis is required when Type of Claim (MC094) = 002 and Type of Bill on Facility Claims (MC036) = 011x, 018x, 021x, 028x, 041x, 065x, 066x, 084x, 086x or 089x.	MC039	Admitting Diagnosis	98	A1
3775	89,605	2009	The Admitting Diagnosis is required when Type of Claim (MC094) = 002 and Type of Bill on Facility Claims (MC036) = 011x, 018x, 021x, 028x, 041x, 065x, 066x, 084x, 086x or 089x.	MC039	Admitting Diagnosis	98	A1

Edit ID	Number of Errors	Submission Year	Message	Data Element	Element Name	Threshold	Field Level
3775	142,880	2010	The Admitting Diagnosis is required when Type of Claim (MC094) = 002 and Type of Bill on Facility Claims (MC036) = 011x, 018x, 021x, 028x, 041x, 065x, 066x, 084x, 086x or 089x.	MC039	Admitting Diagnosis	98	A1
1971	42,261	2008	E-Code must be within the valid domain of values.	MC040	E-Code	3	C
1971	42,625	2009	E-Code must be within the valid domain of values.	MC040	E-Code	3	C
1971	46,976	2010	E-Code must be within the valid domain of values.	MC040	E-Code	3	C
1972	380,104	2008	Principal Diagnosis must be within the valid domain of values.	MC041	Principal Diagnosis	99	A0
1972	488,216	2009	Principal Diagnosis must be within the valid domain of values.	MC041	Principal Diagnosis	99	A0
1972	302,963	2010	Principal Diagnosis must be within the valid domain of values.	MC041	Principal Diagnosis	99	A0
2130	4,661,051	2008	Principal Diagnosis is required.	MC041	Principal Diagnosis	99	A0
2130	5,785,745	2009	Principal Diagnosis is required.	MC041	Principal Diagnosis	99	A0
2130	2,713,218	2010	Principal Diagnosis is required.	MC041	Principal Diagnosis	99	A0
2714	182,836	2008	Other Diagnosis – 1 must be within the valid domain of values.	MC042	Other Diagnosis – 1	70	B
2714	210,975	2009	Other Diagnosis – 1 must be within the valid domain of values.	MC042	Other Diagnosis – 1	70	B
2714	33,527	2010	Other Diagnosis – 1 must be within the valid domain of values.	MC042	Other Diagnosis – 1	70	B
2715	65,173	2008	Other Diagnosis – 2 must be within the valid domain of values.	MC043	Other Diagnosis – 2	24	B
2715	125,996	2009	Other Diagnosis – 2 must be within the valid domain of values.	MC043	Other Diagnosis – 2	24	B
2715	9,646	2010	Other Diagnosis – 2 must be within the valid domain of values.	MC043	Other Diagnosis – 2	24	B
2716	31,060	2008	Other Diagnosis – 3 must be within the valid domain of values.	MC044	Other Diagnosis – 3	13	C
2716	103,683	2009	Other Diagnosis – 3 must be within the valid domain of values.	MC044	Other Diagnosis – 3	13	C
2716	7,586	2010	Other Diagnosis – 3 must be within the valid domain of values.	MC044	Other Diagnosis – 3	13	C
2717	13,252	2008	Other Diagnosis – 4 must be within the valid domain of values.	MC045	Other Diagnosis – 4	7	C
2717	90,748	2009	Other Diagnosis – 4 must be within the valid domain of values.	MC045	Other Diagnosis – 4	7	C
2717	1,974	2010	Other Diagnosis – 4 must be within the valid domain of values.	MC045	Other Diagnosis – 4	7	C
2718	9,291	2008	Other Diagnosis – 5 must be within the valid domain of values.	MC046	Other Diagnosis – 5	4	C
2718	86,734	2009	Other Diagnosis – 5 must be within the valid domain of values.	MC046	Other Diagnosis – 5	4	C

Edit ID	Number of Errors	Submission Year	Message	Data Element	Element Name	Threshold	Field Level
2718	1,571	2010	Other Diagnosis – 5 must be within the valid domain of values.	MC046	Other Diagnosis – 5	4	C
2719	7,280	2008	Other Diagnosis – 6 must be within the valid domain of values.	MC047	Other Diagnosis – 6	3	C
2719	83,460	2009	Other Diagnosis – 6 must be within the valid domain of values.	MC047	Other Diagnosis – 6	3	C
2719	1,389	2010	Other Diagnosis – 6 must be within the valid domain of values.	MC047	Other Diagnosis – 6	3	C
2720	116,828	2008	Other Diagnosis – 7 must be within the valid domain of values.	MC048	Other Diagnosis – 7	3	C
2720	255,687	2009	Other Diagnosis – 7 must be within the valid domain of values.	MC048	Other Diagnosis – 7	3	C
2720	226,032	2010	Other Diagnosis – 7 must be within the valid domain of values.	MC048	Other Diagnosis – 7	3	C
2721	3,599	2008	Other Diagnosis – 8 must be within the valid domain of values.	MC049	Other Diagnosis – 8	2	C
2721	76,893	2009	Other Diagnosis – 8 must be within the valid domain of values.	MC049	Other Diagnosis – 8	2	C
2721	1,054	2010	Other Diagnosis – 8 must be within the valid domain of values.	MC049	Other Diagnosis – 8	2	C
2722	2,009	2008	Other Diagnosis – 9 must be within the valid domain of values.	MC050	Other Diagnosis – 9	1	C
2722	72,242	2009	Other Diagnosis – 9 must be within the valid domain of values.	MC050	Other Diagnosis – 9	1	C
2722	1,633	2010	Other Diagnosis – 9 must be within the valid domain of values.	MC050	Other Diagnosis – 9	1	C
2723	550	2008	Other Diagnosis – 10 must be within the valid domain of values.	MC051	Other Diagnosis – 10	1	C
2723	65,683	2009	Other Diagnosis – 10 must be within the valid domain of values.	MC051	Other Diagnosis – 10	1	C
2723	428	2010	Other Diagnosis – 10 must be within the valid domain of values.	MC051	Other Diagnosis – 10	1	C
2724	633	2008	Other Diagnosis – 11 must be within the valid domain of values.	MC052	Other Diagnosis – 11	1	C
2724	65,240	2009	Other Diagnosis – 11 must be within the valid domain of values.	MC052	Other Diagnosis – 11	1	C
2724	237	2010	Other Diagnosis – 11 must be within the valid domain of values.	MC052	Other Diagnosis – 11	1	C
2725	364	2008	Other Diagnosis – 12 must be within the valid domain of values.	MC053	Other Diagnosis – 12	1	C

Edit ID	Number of Errors	Submission Year	Message	Data Element	Element Name	Threshold	Field Level
2725	65,052	2009	Other Diagnosis – 12 must be within the valid domain of values.	MC053	Other Diagnosis – 12	1	C
2725	188	2010	Other Diagnosis – 12 must be within the valid domain of values.	MC053	Other Diagnosis – 12	1	C
1973	24,625,050	2008	Revenue Code must be within the valid domain of values.	MC054	Revenue Code	90	A0
1973	25,261,496	2009	Revenue Code must be within the valid domain of values.	MC054	Revenue Code	90	A0
1973	18,356,454	2010	Revenue Code must be within the valid domain of values.	MC054	Revenue Code	90	A0
3777	16,384,074	2008	The Revenue Code is required when Type of Claim (MC094) = 002.	MC054	Revenue Code	90	A0
3777	14,873,653	2009	The Revenue Code is required when Type of Claim (MC094) = 002.	MC054	Revenue Code	90	A0
3777	12,659,681	2010	The Revenue Code is required when Type of Claim (MC094) = 002.	MC054	Revenue Code	90	A0
1974	1,401,785	2008	Procedure Code must be within the valid domain of values.	MC055	Procedure Code	92	A1
1974	1,886,130	2009	Procedure Code must be within the valid domain of values.	MC055	Procedure Code	92	A1
1974	1,240,007	2010	Procedure Code must be within the valid domain of values.	MC055	Procedure Code	92	A1
1975	28,078,791	2008	Procedure Modifier - 1 must be within the valid domain of values.	MC056	Procedure Modifier - 1	20	B
1975	31,391,236	2009	Procedure Modifier - 1 must be within the valid domain of values.	MC056	Procedure Modifier - 1	20	B
1975	32,744,581	2010	Procedure Modifier - 1 must be within the valid domain of values.	MC056	Procedure Modifier - 1	20	B
2148	18	2008	Date of Service – From is required.	MC059	Date of Service – From	98	A0
2148	23	2009	Date of Service – From is required.	MC059	Date of Service – From	98	A0
2148	56	2010	Date of Service – From is required.	MC059	Date of Service – From	98	A0
2568	1	2008	Date of Service – From must be in date format (YYYYMMDD) and cannot be a future date.	MC059	Date of Service – From	98	A0
2568	4	2010	Date of Service – From must be in date format (YYYYMMDD) and cannot be a future date.	MC059	Date of Service – From	98	A0

Edit ID	Number of Errors	Submission Year	Message	Data Element	Element Name	Threshold	Field Level
3662	1	2008	Date of Service - From may not be future date	MC059	Date of Service – From	98	A0
3662	2	2010	Date of Service - From may not be future date	MC059	Date of Service – From	98	A0
2149	103,566	2008	Date of Service – To is required.	MC060	Date of Service – To	98	A0
2149	104,970	2009	Date of Service – To is required.	MC060	Date of Service – To	98	A0
2149	36,341	2010	Date of Service – To is required.	MC060	Date of Service – To	98	A0
2569	44	2008	Date of Service – To must be in date format (YYYYMMDD) and cannot be a future date.	MC060	Date of Service – To	98	A0
2569	29	2009	Date of Service – To must be in date format (YYYYMMDD) and cannot be a future date.	MC060	Date of Service – To	98	A0
2569	38	2010	Date of Service – To must be in date format (YYYYMMDD) and cannot be a future date.	MC060	Date of Service – To	98	A0
3663	44	2008	Date of Service - Thru may not be future date	MC060	Date of Service – To	98	A0
3663	29	2009	Date of Service - Thru may not be future date	MC060	Date of Service – To	98	A0
3663	36	2010	Date of Service - Thru may not be future date	MC060	Date of Service – To	98	A0
2609	1	2010	Quantity must be in integer (no decimal points) format and cannot be negative.	MC061	Quantity	98	A1
3780	829,590	2008	The Quantity is required when Site of Service on NSF CMS 1500 claims is populated or when Type of Bill on Facility Claims equals 012x, 013x, 014x, 022x, 023x, 032x, 033x, 034x, 043x, 071x, 072x, 073x, 074x, 075x, 076x, 079x, 081x, 082x, 083x, or 085x.	MC061	Quantity	98	A1
3780	1,103,069	2009	The Quantity is required when Site of Service on NSF CMS 1500 claims is populated or when Type of Bill on Facility Claims equals 012x, 013x, 014x, 022x, 023x, 032x, 033x, 034x, 043x, 071x, 072x, 073x, 074x, 075x, 076x, 079x, 081x, 082x, 083x, or 085x.	MC061	Quantity	98	A1

Edit ID	Number of Errors	Submission Year	Message	Data Element	Element Name	Threshold	Field Level
3780	273,594	2010	The Quantity is required when Site of Service on NSF CMS 1500 claims is populated or when Type of Bill on Facility Claims equals 012x, 013x, 014x, 022x, 023x, 032x, 033x, 034x, 043x, 071x, 072x, 073x, 074x, 075x, 076x, 079x, 081x, 082x, 083x, or 085x.	MC061	Quantity	98	A1
2151	826,103	2008	Charge Amount is required.	MC062	Charge Amount	99	A0
2151	1,035,472	2009	Charge Amount is required.	MC062	Charge Amount	99	A0
2151	1,142,316	2010	Charge Amount is required.	MC062	Charge Amount	99	A0
2610	118,084	2008	Charge Amount must be in integer (no decimal points) format and cannot be zero.	MC062	Charge Amount	99	A0
2610	2,682	2009	Charge Amount must be in integer (no decimal points) format and cannot be zero.	MC062	Charge Amount	99	A0
2610	16,189	2010	Charge Amount must be in integer (no decimal points) format and cannot be zero.	MC062	Charge Amount	99	A0
2611	NULL	NULL	Paid Amount must be in integer (no decimal points) format and cannot be negative.	MC063	Paid Amount	99	A0
3781	24,507	2008	The Paid Amount is required when Claim Status (MC038) = 01,02,03,19,20, 21.	MC063	Paid Amount	99	A0
3781	29,968	2009	The Paid Amount is required when Claim Status (MC038) = 01,02,03,19,20, 21.	MC063	Paid Amount	99	A0
3781	250,449	2010	The Paid Amount is required when Claim Status (MC038) = 01,02,03,19,20, 21.	MC063	Paid Amount	99	A0
2153	6,061,673	2008	Prepaid Amount is required.	MC064	Prepaid Amount	99	B
2153	7,671,330	2009	Prepaid Amount is required.	MC064	Prepaid Amount	99	B
2153	8,212,561	2010	Prepaid Amount is required.	MC064	Prepaid Amount	99	B
2612	NULL	NULL	Prepaid Amount must be in integer (no decimal points) format and cannot be zero.	MC064	Prepaid Amount	99	B
2154	4,205,711	2008	Copay Amount is required.	MC065	Copay Amount	99	A1
2154	5,517,087	2009	Copay Amount is required.	MC065	Copay Amount	99	A1
2154	906,862	2010	Copay Amount is required.	MC065	Copay Amount	99	A1

Edit ID	Number of Errors	Submission Year	Message	Data Element	Element Name	Threshold	Field Level
2613	NULL	NULL	Copay Amount must be in integer (no decimal points) format and cannot be negative.	MC065	Copay Amount	99	A1
2155	1,284,735	2008	Coinsurance Amount is required.	MC066	Coinsurance Amount	99	A1
2155	1,348,598	2009	Coinsurance Amount is required.	MC066	Coinsurance Amount	99	A1
2155	1,346,735	2010	Coinsurance Amount is required.	MC066	Coinsurance Amount	99	A1
2614	NULL	NULL	Coinsurance Amount must be in integer (no decimal points) format and cannot be negative.	MC066	Coinsurance Amount	99	A1
2156	2,028	2008	Deductible Amount is required.	MC067	Deductible Amount	99	A1
2156	1,273	2009	Deductible Amount is required.	MC067	Deductible Amount	99	A1
2156	296	2010	Deductible Amount is required.	MC067	Deductible Amount	99	A1
2615	NULL	NULL	Deductible Amount must be in integer (no decimal points) format and cannot be negative.	MC067	Deductible Amount	99	A1
2570	7	2010	Discharge Date must be in date format (YYYYMMDD) and cannot be a future date.	MC069	Discharge Date	98	B
3764	227,019	2008	Discharge Date is is required when Type of Bill on Facility Claims equals 011x, 018x, 021x, 028x, 041x, 065x, 066x, 084x, 086x, 089x or Type of Claim = 002 and cannot be less than the Admission Date.	MC069	Discharge Date	98	B
3764	7,956,261	2009	Discharge Date is is required when Type of Bill on Facility Claims equals 011x, 018x, 021x, 028x, 041x, 065x, 066x, 084x, 086x, 089x or Type of Claim = 002 and cannot be less than the Admission Date.	MC069	Discharge Date	98	B
3764	2,595,965	2010	Discharge Date is is required when Type of Bill on Facility Claims equals 011x, 018x, 021x, 028x, 041x, 065x, 066x, 084x, 086x, 089x or Type of Claim = 002 and cannot be less than the Admission Date.	MC069	Discharge Date	98	B
3783	148,668	2008	The DRG is required when Type of Bill on Facility Claims (MC036) equals 011x, 018x, 021x, 028x, 041x, 065x, 066x, 084x, 086x or 089x Discharge Hour (MC022) and Discharge Status (MC023) are populated.	MC071	DRG	20	B
3783	236,677	2009	The DRG is required when Type of Bill on Facility Claims (MC036) equals 011x, 018x, 021x, 028x, 041x, 065x, 066x, 084x, 086x or 089x Discharge Hour (MC022) and Discharge Status (MC023) are populated.	MC071	DRG	20	B

Edit ID	Number of Errors	Submission Year	Message	Data Element	Element Name	Threshold	Field Level
3783	314,194	2010	The DRG is required when Type of Bill on Facility Claims (MC036) equals 011x, 018x, 021x, 028x, 041x, 065x, 066x, 084x, 086x or 089x Discharge Hour (MC022) and Discharge Status (MC023) are populated.	MC071	DRG	20	B
2006	25,790	2008	Drug Code must be within the valid domain of values.	MC075	Drug Code	1	B
2006	118,510	2009	Drug Code must be within the valid domain of values.	MC075	Drug Code	1	B
2006	109,720	2010	Drug Code must be within the valid domain of values.	MC075	Drug Code	1	B
2008	1,469,814	2008	Other ICD-9-CM Procedure Code - 1 must be within the valid domain of values.	MC083	Other ICD-9-CM Procedure Code - 1	1	C
2008	1,585,129	2009	Other ICD-9-CM Procedure Code - 1 must be within the valid domain of values.	MC083	Other ICD-9-CM Procedure Code - 1	1	C
2008	1,544,892	2010	Other ICD-9-CM Procedure Code - 1 must be within the valid domain of values.	MC083	Other ICD-9-CM Procedure Code - 1	1	C
2009	766,791	2008	Other ICD-9-CM Procedure Code - 2 must be within the valid domain of values.	MC084	Other ICD-9-CM Procedure Code - 2	1	C
2009	856,123	2009	Other ICD-9-CM Procedure Code - 2 must be within the valid domain of values.	MC084	Other ICD-9-CM Procedure Code - 2	1	C
2009	801,423	2010	Other ICD-9-CM Procedure Code - 2 must be within the valid domain of values.	MC084	Other ICD-9-CM Procedure Code - 2	1	C
2010	432,262	2008	Other ICD-9-CM Procedure Code - 3 must be within the valid domain of values.	MC085	Other ICD-9-CM Procedure Code - 3	1	C
2010	517,700	2009	Other ICD-9-CM Procedure Code - 3 must be within the valid domain of values.	MC085	Other ICD-9-CM Procedure Code - 3	1	C
2010	456,368	2010	Other ICD-9-CM Procedure Code - 3 must be within the valid domain of values.	MC085	Other ICD-9-CM Procedure Code - 3	1	C
2011	268,371	2008	Other ICD-9-CM Procedure Code - 4 must be within the valid domain of values.	MC086	Other ICD-9-CM Procedure Code - 4	1	C
2011	344,585	2009	Other ICD-9-CM Procedure Code - 4 must be within the valid domain of values.	MC086	Other ICD-9-CM Procedure Code - 4	1	C
2011	279,980	2010	Other ICD-9-CM Procedure Code - 4 must be within the valid domain of values.	MC086	Other ICD-9-CM Procedure Code - 4	1	C

Edit ID	Number of Errors	Submission Year	Message	Data Element	Element Name	Threshold	Field Level
2013	5,691	2008	Other ICD-9-CM Procedure Code - 6 must be within the valid domain of values.	MC088	Other ICD-9-CM Procedure Code - 6	1	C
2013	106,404	2009	Other ICD-9-CM Procedure Code - 6 must be within the valid domain of values.	MC088	Other ICD-9-CM Procedure Code - 6	1	C
2013	67,299	2010	Other ICD-9-CM Procedure Code - 6 must be within the valid domain of values.	MC088	Other ICD-9-CM Procedure Code - 6	1	C
2178	1	2008	Paid Date is required.	MC089	Paid Date	98	A0
2571	NULL	NULL	Paid Date must be in date format (YYYYMMDD) and cannot be a future date.	MC089	Paid Date	98	A0
3658	1	2008	Paid Date must be between the Period Begin and Period End Dates on the Transmittal Record.	MC089	Paid Date	98	A0
2223	3,253,559	2008	Plan Rendering Provider Identifier is required.	MC134	Plan Rendering Provider Identifier	100	A0
2223	3,307,496	2009	Plan Rendering Provider Identifier is required.	MC134	Plan Rendering Provider Identifier	100	A0
2223	3,380,490	2010	Plan Rendering Provider Identifier is required.	MC134	Plan Rendering Provider Identifier	100	A0
2224	76,057,938	2008	Provider Location is required.	MC135	Provider Location	98	B
2224	81,369,176	2009	Provider Location is required.	MC135	Provider Location	98	B
2224	78,666,273	2010	Provider Location is required.	MC135	Provider Location	98	B
2226	75,885	2008	Carrier Specific Unique Member ID is required.	MC137	Carrier Specific Unique Member ID	100	A0
2226	50,761	2009	Carrier Specific Unique Member ID is required.	MC137	Carrier Specific Unique Member ID	100	A0
2226	28,555	2010	Carrier Specific Unique Member ID is required.	MC137	Carrier Specific Unique Member ID	100	A0
1950	NULL	NULL	Member Gender must be within the valid domain of values.	ME013	Member Gender	100	A0
2395	945,602	2009	Member Gender is required.	ME013	Member Gender	100	A0
2395	1,447,557	2010	Member Gender is required.	ME013	Member Gender	100	A0

Edit ID	Number of Errors	Submission Year	Message	Data Element	Element Name	Threshold	Field Level
2396	312	2009	Member Date of Birth is required.	ME014	Member Date of Birth	99	A0
2396	577	2010	Member Date of Birth is required.	ME014	Member Date of Birth	99	A0
2583	9	2009	Member Date of Birth must be in date format (YYYYMMDD) and cannot be a future date.	ME014	Member Date of Birth	99	A0
3844	NULL	NULL	The Member Date of Birth cannot be a future date.	ME014	Member Date of Birth	99	A0
2423	529	2009	Product Enrollment Start Date is required.	ME041	Product Enrollment Start Date	98	A1
2423	13,699	2010	Product Enrollment Start Date is required.	ME041	Product Enrollment Start Date	98	A1
2584	NULL	NULL	Product Enrollment Start Date must be in date format (YYYYMMDD) and cannot be a future date.	ME041	Product Enrollment Start Date	98	A1
2585	5,211	2009	Product Enrollment End Date must be in date format (YYYYMMDD).	ME042	Product Enrollment End Date	98	B
2585	125	2010	Product Enrollment End Date must be in date format (YYYYMMDD).	ME042	Product Enrollment End Date	98	B
3677	9,591	2009	If not NULL, Enrollment End Date must be > Enrollment Start Date	ME042	Product Enrollment End Date	98	B
3677	9,573	2010	If not NULL, Enrollment End Date must be > Enrollment Start Date	ME042	Product Enrollment End Date	98	B
2441	NULL	NULL	Disability Indicator Flag is required.	ME059	Disability Indicator Flag	100	C
2667	NULL	NULL	Disability Indicator Flag must be in integer (no decimal points) format .	ME059	Disability Indicator Flag	100	C

Edit ID	Number of Errors	Submission Year	Message	Data Element	Element Name	Threshold	Field Level
2692	22,290	2009	Disability Indicator Flag must be within the valid domain of values.	ME059	Disability Indicator Flag	100	C
2692	28,356	2010	Disability Indicator Flag must be within the valid domain of values.	ME059	Disability Indicator Flag	100	C
2044	87,837	2009	Member rating category must be within the valid domain of values.	ME076	Member rating category	0	B
2044	151,809	2010	Member rating category must be within the valid domain of values.	ME076	Member rating category	0	B
2463	6,547,724	2009	Medicare Code is required.	ME081	Medicare Code	100	B
2463	6,314,508	2010	Medicare Code is required.	ME081	Medicare Code	100	B
2698	NULL	NULL	Medicare Code must be within the valid domain of values.	ME081	Medicare Code	100	B
2472	3	2009	Carrier Specific Unique Member ID is required.	ME107	Carrier Specific Unique Member ID	100	A0
2472	13,635	2010	Carrier Specific Unique Member ID is required.	ME107	Carrier Specific Unique Member ID	100	A0
1985	122,945	2008	Drug Code must be within the valid domain of values.	PC026	Drug Code	90	A0
1985	120,891	2009	Drug Code must be within the valid domain of values.	PC026	Drug Code	90	A0
1985	109,422	2010	Drug Code must be within the valid domain of values.	PC026	Drug Code	90	A0
2259	180	2008	Drug Code is required.	PC026	Drug Code	90	A0
2259	5,344	2009	Drug Code is required.	PC026	Drug Code	90	A0
2259	710	2010	Drug Code is required.	PC026	Drug Code	90	A0
2265	NULL	NULL	Date Prescription Filled is required.	PC032	Date Prescription Filled	99	A0
2575	NULL	NULL	Date Prescription Filled must be in date format (YYYYMMDD).	PC032	Date Prescription Filled	99	A0
3799	266	2008	The Date Prescription filled cannot be greater than the Date Prescription written.	PC032	Date Prescription Filled	99	A0
3799	364	2009	The Date Prescription filled cannot be greater than the Date Prescription written.	PC032	Date Prescription Filled	99	A0

Edit ID	Number of Errors	Submission Year	Message	Data Element	Element Name	Threshold	Field Level
3799	2,790	2010	The Date Prescription filled cannot be greater than the Date Prescription written.	PC032	Date Prescription Filled	99	A0
2636	NULL	NULL	Paid Amount must be in integer (no decimal points) format and cannot be negative.	PC036	Paid Amount	99	A0
3865	123	2008	The Paid Amount is required when Claim Status (PC025) = 01, 02, 03, 19, 20, 21.	PC036	Paid Amount	99	A0
3865	452	2009	The Paid Amount is required when Claim Status (PC025) = 01, 02, 03, 19, 20, 21.	PC036	Paid Amount	99	A0
3865	341	2010	The Paid Amount is required when Claim Status (PC025) = 01, 02, 03, 19, 20, 21.	PC036	Paid Amount	99	A0
2273	6	2008	Copay Amount is required.	PC040	Copay Amount	99	A1
2273	149	2009	Copay Amount is required.	PC040	Copay Amount	99	A1
2273	19	2010	Copay Amount is required.	PC040	Copay Amount	99	A1
2640	NULL	NULL	Copay Amount must be in integer (no decimal points) format and cannot be negative.	PC040	Copay Amount	99	A1
2274	406,934	2008	Coinsurance Amount is required.	PC041	Coinsurance Amount	99	A1
2274	605,732	2009	Coinsurance Amount is required.	PC041	Coinsurance Amount	99	A1
2274	636,679	2010	Coinsurance Amount is required.	PC041	Coinsurance Amount	99	A1
2641	NULL	NULL	Coinsurance Amount must be in integer (no decimal points) format and cannot be negative.	PC041	Coinsurance Amount	99	A1
2275	439	2008	Deductible Amount is required.	PC042	Deductible Amount	99	A1
2275	2,052	2009	Deductible Amount is required.	PC042	Deductible Amount	99	A1
2275	885	2010	Deductible Amount is required.	PC042	Deductible Amount	99	A1
2642	NULL	NULL	Deductible Amount must be in integer (no decimal points) format and cannot be negative.	PC042	Deductible Amount	99	A1
2276	9,804,808	2008	Prescribing ProviderID is required.	PC043	Prescribing ProviderID	80	A0

Edit ID	Number of Errors	Submission Year	Message	Data Element	Element Name	Threshold	Field Level
2276	7,827,070	2009	Prescribing ProviderID is required.	PC043	Prescribing ProviderID	80	A0
2276	6,836,403	2010	Prescribing ProviderID is required.	PC043	Prescribing ProviderID	80	A0
2296	245	2010	Paid Date is required.	PC063	Paid Date	99	A0
2576	NULL	NULL	Paid Date must be in date format (YYYYMMDD) and cannot be a future date.	PC063	Paid Date	99	A0
3690	68	2008	Paid must be between the Period Begin and Period End Dates on the Transmittal Record.	PC063	Paid Date	99	A0
3690	598	2009	Paid must be between the Period Begin and Period End Dates on the Transmittal Record.	PC063	Paid Date	99	A0
3690	64,805	2010	Paid must be between the Period Begin and Period End Dates on the Transmittal Record.	PC063	Paid Date	99	A0
2299	319,537	2008	Other Insurance Paid Amount is required when PC025 is 02, 03, 20 or 21.	PC066	Other Insurance Paid Amount	90	A2
2299	273,819	2009	Other Insurance Paid Amount is required when PC025 is 02, 03, 20 or 21.	PC066	Other Insurance Paid Amount	90	A2
2299	209,879	2010	Other Insurance Paid Amount is required when PC025 is 02, 03, 20 or 21.	PC066	Other Insurance Paid Amount	90	A2
2644	NULL	NULL	Other Insurance Paid Amount must be in integer (no decimal points) format .	PC066	Other Insurance Paid Amount	90	A2
2645	NULL	NULL	Medicare Paid Amount must be in integer (no decimal points) format .	PC067	Medicare Paid Amount	0	A1
2647	NULL	NULL	Member Self Pay Amount must be in integer (no decimal points) format .	PC069	Member Self Pay Amount	20	B
2315	34,815	2008	Carrier Specific UniqueID is required.	PC107	Carrier Specific UniqueID	100	A0
2315	75,522	2009	Carrier Specific UniqueID is required.	PC107	Carrier Specific UniqueID	100	A0
2315	42,411	2010	Carrier Specific UniqueID is required.	PC107	Carrier Specific UniqueID	100	A0

EXEMPTIONS

Some Payers who carry a limited number of covered lives may request and receive an Exemption to filing claims with the APCD. Such requests are considered on a case by case basis.

VARIANCE PROCESS

Overview

The Variance process is a collaborative effort between the payer and their assigned DHCFP liaison to reach a mutually agreed upon **threshold percentage** for any data element which may not meet the APCD standard. Payers are allowed to request a lower threshold for specific fields but must provide a business reason (rationale) and, in some cases, a remediation plan for those elements. The Division liaison will carefully review the request and follow up with a discussion about how to improve data quality and suggest alternatives.

Once this process is complete, the variance template is loaded into production so that any submissions from the payer are held to the DHCFP standard thresholds and any approved variances. The payer receives a report after each submission is processed which compares their data against the required threshold percentages. 'Failed' files are reviewed by the Division liaisons and discussed with the payer for corrective action.

Currently these variances are developed and adjusted on an ongoing basis as payers improve their systems and collect more complete data and thus no longer need a lower threshold. In the future of APCD, variances will be reviewed and updated on a yearly basis.

Examples:

- An example of an approved variance is for the Other Diagnosis fields on the Medical Claim file (data elements MC042 – MC053). To pay claims, it wasn't necessary for a particular carrier to retain more than the Primary or Admitting Diagnosis from claim forms so their historical data was allowed to have lower thresholds on these data elements. However, in working with their liaison, they have a remediation plan in place to start collecting this information going forward in 2012, thus eliminating the need for lower thresholds on these fields and improving the quality of the data.
- Payers may also use this process to request certain file type variances (i.e. a vision payer requesting a variance from having to submit pharmacy or dental claim files).

Variance Analysis

Following is a table of data elements with information about the **threshold Variance % requests** for each indicated data element. There is a row in the table for every data element with an accepted Variance request.

N	Number of Payers requesting Variances on the indicated data element	**Sum of Payers** with accepted variances
Mean	Mean of the threshold Variance requests	**Sum of Variance %'s** / **N**
Median	Midpoint of the threshold Variance requests	**50%** of the Variance Requests are at **Median** or less
Minimum	The minimum Variance% requested	**Lowest %** requested
Maximum	The maximum Variance% requested	**Highest %** requested

Analysis Notes:

- Threshold Submissions lower than expected for Public and Restricted Data Elements - as of October, 2012
- The analysis excludes Payers that are exempt for submission, and also excludes variance requests that were equal to the expected threshold submission.

- The Expected Thresholds displayed are from the current lookup table on the APCD server. A few of the data element thresholds are temporarily relaxed to zero there until they become applicable to submissions.

Data Element	Data Element Description	Edit Level	Release Indicator P=Public, R=Restricted	Expected Threshold	N	Mean	Minimum	Maximum
DC005A	Version Number	A0	P	100	3	0	0	0
DC006	Insured Group or Policy Number	C	R	98	1	0	0	0
DC011	Individual Relationship Code	B	R	98	3	72	50	85
DC012	Member Gender	B	P	100	1	19	19	19
DC014	Member City Name	B	R	99	1	95	95	95
DC017	Date Service Approved (AP Date)	C	R	98	1	89	89	89
DC018	Service Provider Number	A1	R	100	10	14	0	95
DC019	Service Provider Tax ID Number	C	R	99	10	23	0	95
DC020	National Service Provider ID	C	P	98	28	32	0	90
DC021	Service Provider Entity Type Qualifier	A0	P	98	5	0	0	0
DC022	Service Provider First Name	C	P	98	16	42	0	90
DC023	Service Provider Middle Name	C	P	2	15	0	0	0
DC024	Service Provider Last Name or Organization Name	B	P	98	5	0	0	0
DC026	Service Provider Specialty	B	P	98	11	13	0	50
DC027	Service Provider City Name	B	P	98	5	0	0	0
DC028	Service Provider State	B	P	98	5	0	0	0
DC029	Service Provider ZIP Code	B	P	98	7	25	0	96
DC030	Facility Type - Professional	B	P	80	9	0	0	2
DC031	Claim Status	A0	P	90	2	70	70	70
DC032	CDT Code	A2	P	99	3	73	43	90
DC035	Date of Service - From	A0	R	99	1	80	80	80
DC037	Charge Amount	A0	P	99	3	80	50	98
DC039	Copay Amount	A1	P	99	1	0	0	0
DC042	Product ID Number	A0	R	100	1	0	0	0
DC044	Billing Provider Tax ID Number	C	R	90	3	43	0	80
DC056	CarrierSpecificUniqueMemberID	A0	R	100	1	0	0	0
DC057	CarrierSpecificUniqueSubscriberID	A0	R	100	1	0	0	0
DC059	Claim Line Type	A0	P	80	1	0	0	0

Data Element	Data Element Description	Edit Level	Release Indicator P=Public, R=Restricted	Expected Threshold	N	Mean	Minimum	Maximum
MC003	Insurance Type Code/Product	C	R	92	1	0	0	0
MC005A	Version Number	A0	P	100	7	0	0	0
MC006	Insured Group or Policy Number	C	R	95	3	0	0	0
MC011	Individual Relationship Code	B	R	98	1	70	70	70
MC014	Member City Name	B	R	98	1	50	50	50
MC015	Member State or Province	B	P	98	2	25	0	50
MC017	Date Service Approved (AP Date)	C	R	93	1	90	90	90
MC018	Admission Date	A1	R	98	11	64	0	97
MC019	Admission Hour	C	R	5	5	0	0	0
MC020	Admission Type	A1	P	98	13	61	0	96
MC021	Admission Source	A1	P	80	5	30	0	75
MC022	Discharge Hour	C	R	5	4	0	0	0
MC023	Discharge Status	A1	P	98	10	66	0	97
MC024	Service Provider Number	A1	R	99	18	24	0	98
MC025	Service Provider Tax ID Number	C	R	97	20	29	0	92
MC026	National Service Provider ID	C	P	95	32	32	0	93
MC027	Service Provider Entity Type Qualifier	A0	P	98	12	4	0	49
MC028	Service Provider First Name	C	P	92	24	33	0	85
MC029	Service Provider Middle Name	C	P	2	17	0	0	0
MC030	Servicing Provider Last Name or Organization Name	A2	P	94	17	17	0	80
MC031	Service Provider Suffix	Z	P	2	14	0	0	1
MC032	Service Provider Specialty	B	P	98	19	45	0	95
MC033	Service Provider City Name	B	P	98	15	33	0	95
MC034	Service Provider State	B	P	98	15	34	0	97
MC035	Service Provider ZIP Code	B	P	98	18	38	0	97
MC036	Type of Bill - on Facility Claims	A0	P	90	10	60	0	89
MC037	Site of Service - on NSF/CMS 1500 Claims	A0	P	65	4	42	0	63
MC038	Claim Status	A0	P	98	4	53	0	70
MC039	Admitting Diagnosis	A1	P	98	10	51	0	97
MC040	E-Code	C	P	3	19	1	0	2
MC041	Principal Diagnosis	A0	P	99	12	79	0	97
MC042	Other Diagnosis - 1	B	P	70	12	40	0	60

Data Element	Data Element Description	Edit Level	Release Indicator P=Public, R=Restricted	Expected Threshold	N	Mean	Minimum	Maximum
MC043	Other Diagnosis - 2	B	P	24	6	12	0	20
MC044	Other Diagnosis - 3	C	P	13	5	3	0	10
MC045	Other Diagnosis - 4	C	P	7	20	1	0	5
MC046	Other Diagnosis - 5	C	P	4	21	0	0	3
MC047	Other Diagnosis - 6	C	P	3	21	0	0	2
MC048	Other Diagnosis - 7	C	P	3	21	0	0	2
MC049	Other Diagnosis - 8	C	P	2	23	0	0	2
MC050	Other Diagnosis - 9	C	P	1	24	0	0	0
MC051	Other Diagnosis - 10	C	P	1	24	0	0	0
MC052	Other Diagnosis - 11	C	P	1	24	0	0	0
MC053	Other Diagnosis - 12	C	P	1	24	0	0	0
MC054	Revenue Code	A0	P	90	14	41	0	89
MC055	Procedure Code	A1	P	92	7	22	0	75
MC056	Procedure Modifier - 1	B	P	20	15	10	0	18
MC057	Procedure Modifier - 2	B	P	3	16	1	0	2
MC058	ICD9-CM Procedure Code	A2	P	66	11	12	0	45
MC060	Date of Service - To	A0	R	98	4	20	0	80
MC062	Charge Amount	A0	P	99	14	84	30	98
MC063	Paid Amount	A0	P	99	2	95	95	95
MC064	Prepaid Amount	B	P	99	7	0	0	0
MC065	Copay Amount	A1	P	99	2	0	0	0
MC066	Coinsurance Amount	A1	P	99	1	0	0	0
MC067	Deductible Amount	A1	P	99	2	0	0	0
MC068	Patient Control Number	A2	R	10	7	1	0	5
MC069	Discharge Date	B	R	98	9	55	0	96
MC070	Service Provider Country Code	C	P	98	6	30	0	94
MC071	DRG	B	P	20	12	1	0	10
MC072	DRG Version	B	P	20	22	0	0	10
MC073	APC	C	P	20	30	0	0	10
MC074	APC Version	C	P	20	35	0	0	10
MC075	Drug Code	B	P	1	27	0	0	1
MC076	Billing Provider Number	B	R	99	14	54	0	98

Data Element	Data Element Description	Edit Level	Release Indicator P=Public, R=Restricted	Expected Threshold	N	Mean	Minimum	Maximum
MC077	National Billing Provider ID	B	P	99	37	42	0	98
MC078	Billing Provider Last Name or Organization Name	B	P	99	12	16	0	98
MC079	Product ID Number	A0	R	100	4	72	0	96
MC080	Reason for Adjustment	A1	R	80	22	7	0	75
MC081	Capitated Encounter Flag	A0	P	100	1	0	0	0
MC083	Other ICD-9-CM Procedure Code - 1	C	P	1	11	0	0	0
MC084	Other ICD-9-CM Procedure Code - 2	C	P	1	13	0	0	0
MC085	Other ICD-9-CM Procedure Code - 3	C	P	1	15	0	0	1
MC086	Other ICD-9-CM Procedure Code - 4	C	P	1	18	0	0	0
MC087	Other ICD-9-CM Procedure Code - 5	C	P	1	19	0	0	0
MC088	Other ICD-9-CM Procedure Code - 6	C	P	1	22	0	0	0
MC089	Paid Date	A0	P	98	1	0	0	0
MC092	Covered Days	B	P	80	11	16	0	60
MC093	Non Covered Days	B	P	80	13	3	0	40
MC094	Type of Claim	A0	P	100	5	73	0	99
MC096	Other Insurance Paid Amount	A2	P	90	5	0	0	0
MC097	Medicare Paid Amount	B	P	98	10	0	0	0
MC098	Allowed amount	A2	R	99	2	45	0	89
MC099	Non-Covered Amount	B	P	98	2	42	0	83
MC111	Diagnostic Pointer	B	P	90	26	17	0	88
MC112	Referring Provider ID	B	R	98	17	11	0	93
MC113	Payment Arrangement Type	A0	P	90	10	19	0	55
MC114	Excluded Expenses	B	P	80	10	4	0	40
MC115	Medicare Indicator	A0	P	100	4	0	0	0
MC116	Withhold Amount	B	P	80	13	0	0	0
MC117	Authorization Needed	B	P	100	7	0	0	0
MC118	Referral Indicator	A0	P	100	4	0	0	0
MC119	PCP Indicator	B	P	100	3	0	0	0
MC120	DRG Level	B	P	80	26	2	0	40
MC122	Global Payment Flag	A0	P	100	4	0	0	0
MC123	Denied Flag	A0	P	100	1	0	0	0
MC124	Denial Reason	B	R	80	7	24	0	78

Data Element	Data Element Description	Edit Level	Release Indicator P=Public, R=Restricted	Expected Threshold	N	Mean	Minimum	Maximum
MC125	Attending Provider	A1	R	98	28	38	0	96
MC126	Accident Indicator	B	P	100	5	15	0	75
MC128	Employment Related Indicator	B	P	100	5	15	0	75
MC130	Procedure Code Type	A1	P	80	4	24	0	50
MC134	Plan Rendering Provider Identifier	A0	R	100	20	40	0	98
MC135	Provider Location	B	R	98	23	32	0	92
MC136	Discharge Diagnosis	B	P	80	15	17	0	78
MC137	CarrierSpecificUniqueMemberID	A0	R	100	1	0	0	0
MC138	Claim Line Type	A0	P	90	1	0	0	0
MC141	CarrierSpecificUniqueSubscriberID	A0	R	100	1	0	0	0
ME003	Insurance Type Code/Product	A1	P	96	3	28	0	85
ME006	Insured Group or Policy Number	A2	R	99	2	0	0	0
ME007	Coverage Level Code	A1	P	99	2	0	0	0
ME012	Individual Relationship Code	A0	R	97	1	80	80	80
ME013	Member Gender	A0	P	100	1	19	19	19
ME015	Member City Name	A0	R	99	3	79	50	98
ME016	Member State or Province	A0	P	99	4	60	0	98
ME018	Medical Coverage	A0	P	100	1	100	100	100
ME020	Dental Coverage	A0	P	100	1	0	0	0
ME021	Race 1	B	P	3	46	0	0	2
ME022	Race 2	C	P	2	46	0	0	0
ME023	Other Race	C	P	99	42	0	0	1
ME024	Hispanic Indicator	B	P	3	41	0	0	1
ME025	Ethnicity 1	B	P	3	46	0	0	2
ME026	Ethnicity 2	C	P	2	46	0	0	0
ME027	Other Ethnicity	C	P	99	42	0	0	0
ME029	Coverage Type	A0	P	90	1	0	0	0
ME030	Market Category Code	A0	P	95	6	2	0	10
ME033	Member language preference	B	P	3	32	0	0	2
ME034	Member language preference -Other	C	P	99	28	0	0	0
ME035	Health Care Home Assigned Flag	B	P	20	14	0	0	0
ME036	Health Care Home Number	C	R	90	18	0	0	0

Data Element	Data Element Description	Edit Level	Release Indicator P=Public, R=Restricted	Expected Threshold	N	Mean	Minimum	Maximum
ME037	Health Care Home Tax ID Number	C	P	90	18	0	0	0
ME038	Health Care Home National Provider ID	C	P	10	18	0	0	0
ME039	Health Care Home Name	C	P	90	18	0	0	0
ME040	Product ID Number	A0	R	100	7	12	0	85
ME041	Product Enrollment Start Date	A1	R	98	1	85	85	85
ME042	Product Enrollment End Date	B	R	98	6	35	0	95
ME046	Member PCP ID	B	R	98	14	8	0	97
ME047	Member PCP Effective Date	B	P	98	18	6	0	97
ME048	Member PCP Termination Date	B	P	98	19	6	0	97
ME049	Member Deductible	A2	P	90	21	8	0	80
ME051	Behavioral Health Benefit Flag	B	P	100	3	0	0	0
ME052	Laboratory Benefit Flag	B	P	100	1	0	0	0
ME053	Disease Management Enrollee Flag	B	P	100	6	15	0	93
ME059	Disability Indicator Flag	C	P	100	4	0	0	0
ME061	Student Status	A0	P	100	6	13	0	75
ME062	Marital Status	B	P	100	10	13	0	80
ME063	Benefit Status	B	P	100	5	0	0	0
ME064	Employee Type	C	P	100	14	0	0	0
ME073	Fully insured member	A0	P	100	1	0	0	0
ME077	Members SIC Code	C	P	2	26	0	0	0
ME081	Medicare Code	B	P	100	10	0	0	0
ME107	CarrierSpecificUniqueMemberID	A0	R	100	3	32	0	95
ME108	Subscriber City Name	A0	R	98	2	93	90	96
ME109	Subscriber State or Province	A0	P	99	5	96	90	98
ME111	Medical Deductible	B	P	90	24	9	0	80
ME112	Pharmacy Deductible	B	P	90	29	5	0	75
ME113	Medical and Pharmacy Deductible	B	P	90	25	1	0	20
ME114	Behavioral Health Deductible	B	P	90	27	0	0	10
ME115	Dental Deductible	B	P	90	22	6	0	80
ME116	Vision Deductible	B	P	90	24	0	0	5
ME117	CarrierSpecificUniqueSubscriberID	A0	R	100	3	65	0	99
ME118	Vision Benefit	A0	P	100	3	0	0	0

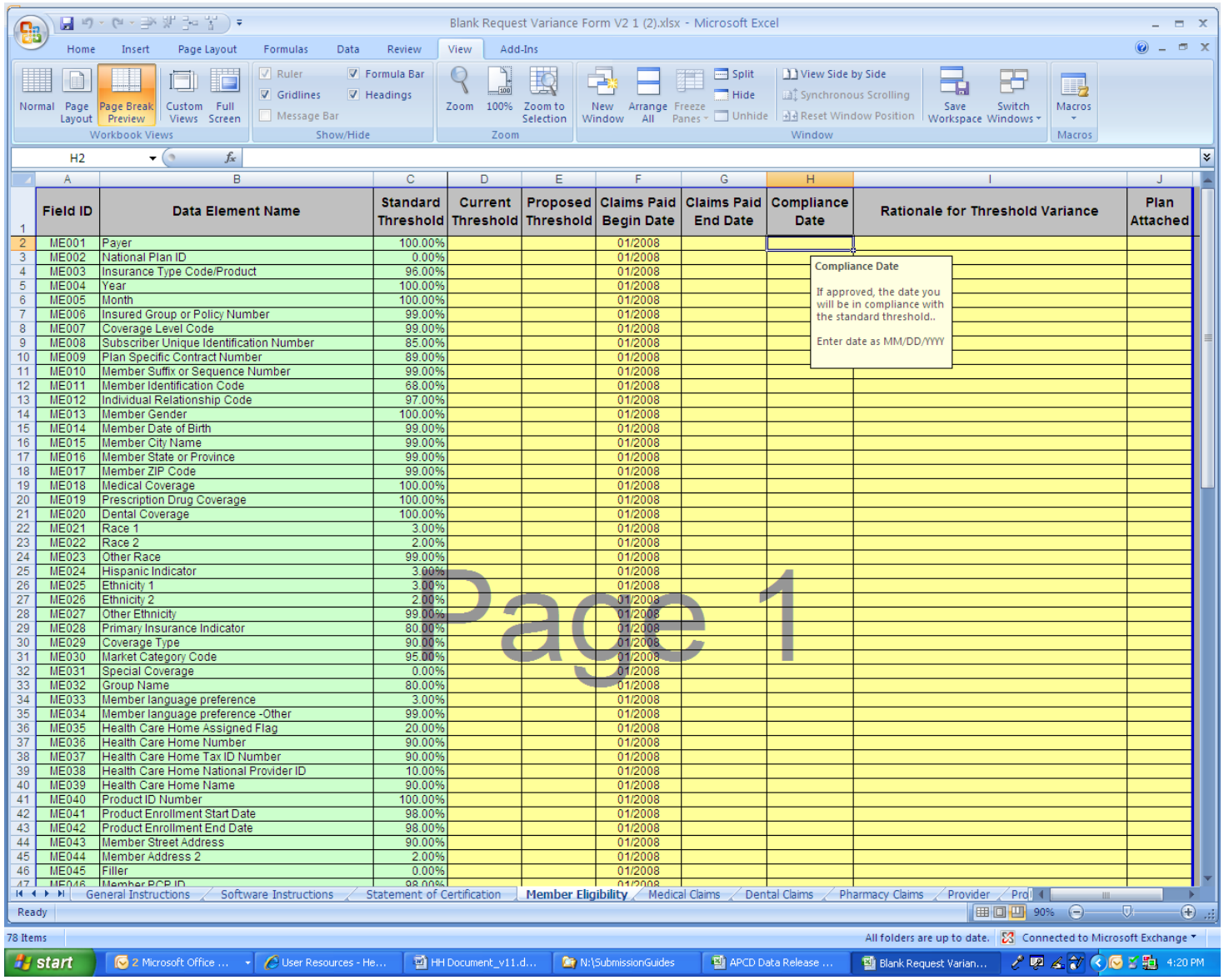
Data Element	Data Element Description	Edit Level	Release Indicator P=Public, R=Restricted	Expected Threshold	N	Mean	Minimum	Maximum
PC003	Insurance Type Code/Product	C	R	95	2	47	0	93
PC006	Insured Group or Policy Number	C	R	98	1	0	0	0
PC011	Individual Relationship Code	B	R	85	3	75	70	80
PC014	Member City Name of Residence	B	R	99	2	94	90	97
PC015	Member State	B	P	99	1	90	90	90
PC018	Pharmacy Number	A0	R	98	1	0	0	0
PC019	Pharmacy Tax ID Number	C	R	20	9	0	0	0
PC020	Pharmacy Name	A2	P	90	2	40	0	80
PC021	National Pharmacy ID Number	C	P	98	6	68	1	95
PC022	Pharmacy Location City	B	P	85	2	40	0	80
PC023	Pharmacy Location State	B	P	90	2	40	0	80
PC024	Pharmacy ZIP Code	B	P	90	3	47	0	80
PC024A	Pharmacy Country Code	B	P	90	3	0	0	0
PC025	Claim Status	A0	P	65	2	0	0	0
PC026	Drug Code	A0	P	90	2	87	86	88
PC028	New Prescription or Refill	A0	P	99	1	0	0	0
PC031	Compound Drug Indicator	C	P	98	3	0	0	0
PC033	Quantity Dispensed	A1	P	99	6	57	0	96
PC034	Days Supply	A2	P	99	2	48	0	96
PC035	Charge Amount	A0	P	99	3	32	0	96
PC037	Ingredient Cost/List Price	A1	P	99	1	0	0	0
PC038	Postage Amount Claimed	C	P	99	8	0	0	0
PC039	Dispensing Fee	A1	P	99	1	0	0	0
PC041	Coinsurance Amount	A1	P	99	7	0	0	0
PC043	Prescribing ProviderID	A0	R	80	14	21	0	72
PC044	Prescribing Physician First Name	B	P	50	6	2	0	12
PC045	Prescribing Physician Middle Name	C	P	2	16	0	0	0
PC046	Prescribing Physician Last Name	B	P	50	5	14	0	40
PC047	Prescribing Physician DEA Number	B	R	80	17	11	0	50
PC048	Prescribing Physician NPI	C	P	80	11	34	0	75
PC049	Prescribing Physician Plan Number	C	P	10	15	0	0	0
PC050	Prescribing Physician License Number	B	P	10	19	0	0	0

Data Element	Data Element Description	Edit Level	Release Indicator P=Public, R=Restricted	Expected Threshold	N	Mean	Minimum	Maximum
PC051	Prescribing Physician Street Address	C	R	10	8	1	0	4
PC052	Prescribing Physician Street Address 2	C	R	2	6	0	0	0
PC053	Prescribing Physician City	C	P	10	6	0	0	0
PC054	Prescribing Physician State	C	P	10	6	0	0	0
PC055	Prescribing Physician Zip	C	P	10	6	0	0	0
PC056	Product ID Number	A0	R	100	6	62	0	99
PC057	Mail Order pharmacy	B	P	100	1	0	0	0
PC058	Script number	B	R	100	3	0	0	0
PC059	Recipient PCP ID	B	R	98	25	4	0	79
PC060	Single/Multiple Source Indicator	B	P	90	2	0	0	0
PC062	Billing Provider Tax ID Number	C	R	90	20	30	0	85
PC064	Date Prescription Written	B	R	80	7	11	0	77
PC066	Other Insurance Paid Amount	A2	P	90	6	12	0	70
PC068	Allowed amount	A2	R	99	7	2	0	15
PC069	Member Self Pay Amount	B	P	20	15	0	0	0
PC070	Rebate Indicator	B	P	85	7	0	0	0
PC073	Formulary Code	A0	P	90	2	0	0	0
PC074	Route of Administration	B	P	80	4	0	0	0
PC075	Drug Unit of Measure	A1	P	80	7	17	0	77
PC107	CarrierSpecificUniqueMemberID	A0	R	100	3	66	0	99
PC108	CarrierSpecificUniqueSubscriberID	A0	R	100	4	99	98	99
PC110	Claim Line Type	A0	P	90	2	80	80	80
PR002	Product Name	C	R	100	1	0	0	0
PR003	Carrier License Type	A0	R	100	5	0	0	0
PR004	Product Line of Business Model	A0	R	100	7	58	0	98
PR005	Insurance Plan Market	A0	R	100	5	41	0	98
PR006	Product Benefit Type	A0	P	100	4	25	0	98
PR007	Other Product Benefit Description	B	R	100	6	20	0	90
PR008	Risk Type	A2	P	100	3	32	0	95
PR009	Product Start Date	A0	R	100	6	0	0	0
PR010	Product End Date	B	R	100	5	0	0	0
PR011	Product Active Flag	C	P	100	1	0	0	0

Data Element	Data Element Description	Edit Level	Release Indicator P=Public, R=Restricted	Expected Threshold	N	Mean	Minimum	Maximum
PR012	Annual Per Person Deductible Code	B	P	100	10	2	0	20
PR013	Annual Per Family Deductible Code	B	P	100	10	2	0	20
PR014	Coordinated Care model	C	P	100	6	16	0	98
PR899	Record Type	A0	P	100	1	0	0	0
PV001	Payer	A0	R	100	2	1	0	2
PV002	Plan Provider ID	A0	R	100	4	35	3	96
PV003	Tax Id	A2	R	98	17	61	0	97
PV005	DEA ID	B	R	98	33	28	0	96
PV006	License Id	B	P	80	20	15	0	74
PV008	Last Name	A0	P	98	6	58	0	95
PV009	First Name	A2	P	98	14	43	0	95
PV010	Middle Initial	C	P	1	12	0	0	0
PV011	Suffix	Z	P	1	18	0	0	1
PV012	Entity Name	A1	P	98	7	41	0	80
PV013	Entity Code	A0	P	98	17	23	0	93
PV014	Gender Code	B	P	20	9	0	0	0
PV016	Street Address1 Name	A1	R	98	6	74	1	95
PV017	Street Address2 Name	A0	R	2	2	0	0	0
PV018	City Name	A1	P	98	6	75	1	95
PV019	State Code	A0	P	98	4	68	1	95
PV020	Country Code	C	P	98	5	53	0	90
PV021	Zip Code	A0	P	98	7	63	0	95
PV022	Taxonomy	C	P	50	35	8	0	40
PV023	Mailing Street Address1 Name	A0	P	98	5	53	0	95
PV024	Mailing Street Address2 Name	B	P	2	2	0	0	0
PV025	Mailing City Name	A0	P	98	4	54	1	95
PV026	Mailing State Code	A0	P	98	3	42	1	95
PV027	Mailing Country Code	C	P	98	4	30	0	90
PV028	Mailing Zip Code	A0	P	98	5	65	1	95
PV029	Provider Type Code	A1	P	98	8	45	0	90
PV030	Primary Specialty Code	B	P	98	16	45	0	93
PV034	ProviderIDCode	A0	P	100	8	53	0	100

Data Element	Data Element Description	Edit Level	Release Indicator P=Public, R=Restricted	Expected Threshold	N	Mean	Minimum	Maximum
PV035	SSN Id	A1	R	98	48	36	0	94
PV036	Medicare Id	B	R	90	32	4	0	50
PV037	Begin Date	A2	P	98	12	26	0	90
PV038	End Date	B	P	98	8	0	0	0
PV039	National Provider ID	B	P	98	40	43	0	96
PV040	National Provider2 ID	C	P	1	34	0	0	0
PV042	Secondary Specialty2 Code	B	P	1	26	0	0	0
PV045	P4PFlag	B	P	100	8	9	0	74
PV046	NonClaimsFlag	B	P	100	8	10	0	76
PV047	Uses Electronic Medical Records	B	P	100	10	0	0	0
PV049	Accepting New Patients	B	P	100	8	0	0	2
PV050	Offers e-Visits	C	P	100	10	7	0	74
PV052	Has multiple offices	A0	P	100	5	15	0	76
PV055	PCP Flag	A0	P	100	2	38	0	75
PV056	Provider Affiliation	B	R	99	15	14	0	80
PV057	Provider Telephone	C	P	10	4	1	0	2
PV058	Delegated Provider Record Flag	B	P	100	3	1	0	2
PV060	Office Type	A0	P	95	13	1	0	10
PV061	Prescribing Provider	C	P	100	5	20	0	98
PV062	Provider Affiliation Start Date	A0	P	98	24	18	0	88
PV063	Provider Affiliation End Date	B	P	98	19	5	0	30
PV064	PPO Indicator	A0	P	100	3	25	0	76

Example of blank Variance Request form



Field ID	Data Element Name	Standard Threshold	Current Threshold	Proposed Threshold	Claims Paid Begin Date	Claims Paid End Date	Compliance Date	Rationale for Threshold Variance	Plan Attached
ME001	Payer	100.00%			01/2008				
ME002	National Plan ID	0.00%			01/2008				
ME003	Insurance Type Code/Product	96.00%			01/2008				
ME004	Year	100.00%			01/2008				
ME005	Month	100.00%			01/2008				
ME006	Insured Group or Policy Number	99.00%			01/2008				
ME007	Coverage Level Code	99.00%			01/2008				
ME008	Subscriber Unique Identification Number	85.00%			01/2008				
ME009	Plan Specific Contract Number	89.00%			01/2008				
ME010	Member Suffix or Sequence Number	99.00%			01/2008				
ME011	Member Identification Code	68.00%			01/2008				
ME012	Individual Relationship Code	97.00%			01/2008				
ME013	Member Gender	100.00%			01/2008				
ME014	Member Date of Birth	99.00%			01/2008				
ME015	Member City Name	99.00%			01/2008				
ME016	Member State or Province	99.00%			01/2008				
ME017	Member ZIP Code	99.00%			01/2008				
ME018	Medical Coverage	100.00%			01/2008				
ME019	Prescription Drug Coverage	100.00%			01/2008				
ME020	Dental Coverage	100.00%			01/2008				
ME021	Race 1	3.00%			01/2008				
ME022	Race 2	2.00%			01/2008				
ME023	Other Race	99.00%			01/2008				
ME024	Hispanic Indicator	3.00%			01/2008				
ME025	Ethnicity 1	3.00%			01/2008				
ME026	Ethnicity 2	2.00%			01/2008				
ME027	Other Ethnicity	99.00%			01/2008				
ME028	Primary Insurance Indicator	80.00%			01/2008				
ME029	Coverage Type	90.00%			01/2008				
ME030	Market Category Code	95.00%			01/2008				
ME031	Special Coverage	0.00%			01/2008				
ME032	Group Name	80.00%			01/2008				
ME033	Member language preference	3.00%			01/2008				
ME034	Member language preference -Other	99.00%			01/2008				
ME035	Health Care Home Assigned Flag	20.00%			01/2008				
ME036	Health Care Home Number	90.00%			01/2008				
ME037	Health Care Home Tax ID Number	90.00%			01/2008				
ME038	Health Care Home National Provider ID	10.00%			01/2008				
ME039	Health Care Home Name	90.00%			01/2008				
ME040	Product ID Number	100.00%			01/2008				
ME041	Product Enrollment Start Date	98.00%			01/2008				
ME042	Product Enrollment End Date	98.00%			01/2008				
ME043	Member Street Address	90.00%			01/2008				
ME044	Member Address 2	2.00%			01/2008				
ME045	Filler	0.00%			01/2008				
ME046	Member PCP ID	98.00%			01/2008				

CONTACT INFORMATION

The Division of Health Care Finance and Policy is located in downtown Boston, in the China Trade Center, at the corner of Boylston and Washington streets.

Please contact the Division with questions regarding the content and use of the data.

Division of Health Care Finance and Policy
2 Boylston Street, 5th floor
Boston, MA 02116-4734

617-988-3100 (voice)
617-727-7662 (fax)

For general APCD questions, email the APCD mailbox:

dhcfp.apcd@state.ma.us

For questions regarding data requests/applications, email the APCD data application mailbox:

apcd.data@state.ma.us

Appendix 1: Glossary of Terms

Term	Definition
Accident Indicator	A yes/no indicator that originates from the Professional Claims format to assess insurance liabilty, financial responsibility and aid with clinical assessments.
Adjudication Data	Any data that describes how a claim was processed for payment. Typically information that would go back to the provider of services is used, but could include contract level information as well.
Admitting Diagnosis	This is the diagnosis (of a unique set of diagnoses) that supports a physician's order to admit a patient into an inpatient setting at a facility.
All-Payer Claims Database (APCD)	The All Payer Claims Data Base (APCD) is a dataset of members, providers, products and claims from payers that allow for a broad understanding of cost and utilization across institutions and populations.
Ambulatory Payment Classification (APC)	A payment methodology applied to outpatient claims in a facility; defined by Federal Balanced Budget Act for Medicare claims originally.
Ancillary Services	Any service that supports the primary reason for the medical visit. This can be laboratory, X-ray or other services within or outside of the same facility.
APC	See Ambulatory Payment Classification.
APCD	See All-Payer Claims Database.
APCD Field Threshold	The percentage of correct data that needs to be submitted for a particular field to ensure that it "passes". See Variance Request.
Applicant	An individual or organization that requests health care data and information in accordance with 114.5 CMR 22.03.
Attending Provider	A provider that has direct care oversight of the patient. Typically an individual reported on Facility Inpatient Claims.
Billing Provider	A provider entity that sends claims and requests for adjudication to a carrier for payment.
Capitated Encounter Flag	A MA APCD Flag Indicator that reports a line-item as being covered under a capitation arrangement.
Capitated Payment	Capitation is a contractual payment arrangement between provider and payer. It is the 'per member per month' methodology that does not take 'per service' into account during the contract timeframe.
Carrier-Specific Unique Member ID	The number a carrier uses internally to uniquely identify the member.
Carrier-Specific Unique Subscriber ID	This is the number the carrier uses internally to uniquely identify the subscriber.
CDT Code	See Common Dental Terminology Code.
Claim	A request for payment on rendered services to likely members. Claims can be in many formats: see UB04, HIPAA 837, Reimbursement Form, and Direct Data Entry.
Claim Line	An individual service reporting of a claim. See Line Counter.

Term	Definition
Claim Line Type	A MA APCD value that reports a claim line status that moderately relates to the final digit (Frequency Code) of the Type of Bill or Place of Service code on a claim. Options are Original, Void, Replacement, Back Out and Amendment.
Claim Status	A MA APCD value that reports how a claim was processed by the reporting carrier. Relates to reimbursement order on claims.
Claims Adjudication	An evaluation process employed by insurance companies and/or their designees to process claims data for payment to providers.
Claims Data	Information consisting of, or derived directly from, member eligibility information, medical claims, pharmacy claims, dental claims, and all other data submitted by health care payers to the Division.
CMS	See Centers for Medicare & Medicaid Services
COB	See Coordination of Benefits
COBRA	See Consolidated Omnibus Budget Reconciliation Act
Coinsurance Amount	Usually defined as a percentage of the claim that the subscriber pays on covered services to the provider after deductibles have been met, per the plan contract. Also see Cost Sharing and/or Out of Pocket Expense
Common Dental Terminology Code (CDT Code)	A code set developed for dental procedure reporting by the American Dental Association
Compound Drug Indicator	A MA APCD Flag Indicator that reports if a pharmacy line had to be compounded for the patient due to patient-specific needs (weight, allergies, administration route) or unavailability of the drug in certain measures.
Consolidated Omnibus Budget Reconciliation Act (COBRA)	Refers to the COBRA legislation that requires offering continued health care coverage when a qualifying event occurs with the employed family member. Usually only required of large group employers (20+ employees) under a modified payment schedule for same level of coverage.
Coordination of Benefits (COB)	A process that occurs between provider, subscriber(s) of same household, and two or more payers to eliminate multiple primary payments.
Coordination of Benefits/TPL Liability Amount	The amount calculated by a primary payer on a claim as the amount due from a secondary or other payer on the same claim when the primary payer is aware of other payers.
Copayment Amount	Usually defined as a set amount paid by the subscriber to the provider for a given outpatient service, per the plan contract. Also see Cost Sharing and/or Out of Pocket Expense.
Coverage Level Code	A MA APCD value submitted by the carrier that refines a line of eligibility to report the definition and size of covered lives.
Covered Days	The number of inpatient days covered by the plan under the member's eligibility. See Noncovered Days.
Date Service Approved (AP Date)	This is the date that the claim line was approved for payment. It can be several days (or weeks) prior to the Paid Date or on the Paid Date, but cannot fall after the Paid Date.

Term	Definition
DC File	See Dental Claim File
DDE	See Direct Data Entry
Deductible	Usually defined as an annual set amount paid by the subscriber to the provider prior to the plan applying benefits. Deductibles can be inpatient and/or outpatient as they are payer/plan specific. Also see Cost Sharing and/or Out of Pocket Expense.
Delegated Benefit Administrator	DHCFP assigned Org ID for Benefit Administrator. A Delegated Benefit Administrator is an entity that performs a combination of activities related to benefit enrollment, management and premium collection on behalf of a payer.
Denied Claims	Claims and/or Claim Lines that a payer will not process for payment due to non-eligibility or contractual conflicts.
Dental Claim File (DC File)	A MA APCD File Type for reporting all Paid Dental Claim Lines of a given time period. File accommodates Replacement and Void lines.
DHCFP	See Division of Health Care Finance & Policy
Diagnostic Related Group (DRG)	Diagnostic Related Group: A system to classify hospital inpatient admits into a defined set of cases by numeric representation. Payment categories that are used to classify patients for the purpose of reimbursing providers for each case in a given category with a fixed fee regardless of the actual costs incurred.
Disability Indicator Flag	Indicator that a member has a disability. A yes/no indicator that originates from the Professional Claims format to assess insurance liabilty, financial responsibility and aid with clinical assessments.
Disease Management Enrollee Flag	A MA APCD Flag Indicator that reports if a member's chronic illness is managed by plan or vendor of plan.
Dispense as Written Code	Prescription Dispensing Activity Code
Division	See Division of Health Care Finance & Policy
DRG	See Diagnostic Related Group
DRG Level	A reporting refinement from the Diagnostic Related Group coding that reports a level of severity of the case.
DRG Version	The version of the Diagnostic Related Group, a numbering system within the application used to allocate claims into the appropriate grouping date. This is mostly an annual process, although other updates are received.
E-Code	See External Injury Code
EFT	See Electronic Funds Transfer
Employer EIN	Employer Identification Number (Federal Tax Identification Number) of the member's employer.
Employment Related Indicator	Service related to Employment Injury. A yes/no indicator that originates from the Professional Claims format to assess insurance liabilty, financial responsibility and aid with clinical assessments.
Encounter Data	Detailed data about individual services provided by a capitated managed care entity.
EOB	See Explanation of Benefits.

Term	Definition
EPO	See Exclusive Provider Organization.
EPSDT Indicator	Indicates that Early Periodic Screening, Diagnosis and Treatment (EPSDT) were utilized. A yes/no indicator that originates from the Professional Claims format to assess insurance liabilty, financial responsibility and aid with clinical assessments.
Excluded Expenses	Amount that the plan has determined to be above and beyond plan/benefit limitations for a given patient. Related to non-covered services.
Exclusive Provider Organization (EPO)	A managed care product type that requires each member to have a PCP assignment within a limited network but offers affordable coverage.
External Code Source	External code sources are lists of values generally accepted as a standard set of values for a given element. Example: Revenue Codes as defined by the National Uniform Billing Committee.
External Injury Code (E-Code)	ICD Diagnostic External Injury Code for patients with trauma or accidents. A subsection of the International Classification of Diseases Diagnosis Codes that specifically enumerate various types of accidents and traumas before diagnoses are applied.
Fee for Service	A payment methodology where each service rendered is considered for individual reimbursement.
Former Claim Number	This is a prior claim number originally assigned to the claim by the provider of service. Its use in the APCD dataset is usually to aid with versioning of a claim where versioning cannot be applied due to system limitations. See Versioning.
Formulary Code	A MA APCD Flag Indicator that reports a line-item as being listed on a payers list of covered drugs. This reporting helps to understand patient-out-of-pocket expenses.
Fully-Insured	In a fully insured plan, the employer pays a per-employee premium to an insurance company, and the insurance company assumes the risk of providing health coverage for insured events.
GIC	See Group Insurance Commission.
Global Payment	Payments received of a fixed-value for predefined services on members within a predefined time frame.
Global Payment Flag	A MA APCD Flag Indicator that reports a line-item as being paid under a Global Payment arrangement. See Global Payment.
Group Insurance Commission	The Group Insurance Commission (GIC) is an entity charged with overseeing health and tangent benefits of state employees, retirees and dependents.
Grouper	A tool/application that evaluates each claim and determines where the claim falls clinically across a broad spectrum of values (cases). This can be applied to inpatient and outpatient claims based on the grouper used.
Health Care Home	See Patient Centered Medical Home.
Health Care Payer	A Private or Public Health Care Payer that contracts or offers to provide, deliver, arrange for, pay for, or reimburse any of the costs of health services. A Health Care Payer includes an insurance carrier, a health maintenance organization, a nonprofit hospital services corporation, a medical service corporation, Third-Party Administrators,

Term	Definition
	and self-insured plans.
Health Plan Information	Information submitted by Health Care Payers in accordance with 114.5 CMR 21.03(2).
ICD9-CM	See International Classification of Diseases, 9th edition, Clinical Modification.
Individual Relationship Code	Indicator defining the Member/Patient's relationship to the Subscriber.
Insurance Type Code/Product	This field indicates the type of product the member has, such as HMO, PPO, POS, Auto Medical, Indemnity, and Workers Compensation.
International Classification of Diseases, 9th Edition, Clinical Modification	Refers to the International Classification of Diseases, 9th Revision Codes, and Clinical Modification (ICD-9-CM) procedure codes.
Last Activity Date	This is the date that a subscriber's or member's eligibility for any given product was last edited.
Line Counter	An enumeration process to define each service on a claim with a unique number. Process follows standard enumeration from other billing forms and formats.
Logical Observation Identifiers, Names and Codes (LOINC)	Lab Codes for Logical Observation Identifiers, Names and Codes. A method for reporting laboratory findings of specimens back to a health care provider / system.
LOINC	See Logical Observation Identifiers, Names and Codes.
Major Diagnostic Category (MDC)	The Major Diagnostic Categories (MDC) is a classification system that parses all principal diagnoses into one of 25 categories primarily for use with DRGs and reimbursement activity. Each Category relates to a physical system, disease, or contributing health factor.
Managed Care Organization	A product developed to control costs of care management through various methods; i.e., limited network, PCP assignment, case management.
Market Category Code	A MA APCD ME File refinement code that explains what market segment the policy that the subscriber/member has selected falls under.
MassHealth	The Massachusetts Medicaid program.
MC File	See Medical Claim File.
MCO	See Managed Care Organization.
MDC	See Major Diagnostic Categories.
Medicaid MCO	A Medicaid Managed Care Organizations is a private health insurance that has contracted with the state to supply Managed Care products to a select population.
Medical Claim File (MC File)	A MA APCD File Type for reporting all Paid Medical Claim Lines of a given time period. File accommodates Facility, Professional, Reimbursement Forms and Replacement and Void lines.
Medicare Advantage	A Medicare Advantage Plan (Part C) is a Medicare health plan choice offered by private companies approved by Medicare. The plan will provides all Part A (Hospital Insurance) and Part B (Medical Insurance) coverage and may

Term	Definition
	offer extra coverage such as vision or dental coverage
Medicare Benefits (Part A & B)	Health insurance available under Medicare Part A and Part B through the traditional fee-for-service payment system. Part A is hospital insurance that helps cover inpatient care in hospitals, skilled nursing facility, hospice, and home health care. Part B helps cover medically-necessary services like doctors' services, outpatient care, durable medical equipment, home health services, and other medical services.
Member	A person who holds an individual contract or a certificate under a group arrangement contracted with a Health Care Payer.
Member Deductible	Annual maximum out of pocket Member Deductible across all benefit types. See Deductible.
Member Deductible Used	Member deductible amount incurred.
Member Eligibility File	A file that includes data about a person who receives health care coverage from a payer, including but not limited to subscriber and member identifiers; member demographics; race, ethnicity and language information; plan type; benefit codes; enrollment start and end dates; and behavioral and mental health, substance abuse and chemical dependency and prescription drug benefit indicators.
Member PCP Effective Date	Begin date for member enrollment with Primary Care Provider (PCP).
Member PCP ID	The member's Primary Care Physician's ID.
Member PCP Termination Date	Member termination date from that Primary Care Provider (PCP).
Member Rating Category	Utilized for Medicaid MCO members only, it defines the Member Medicaid MCO category.
Member Self Pay Amount	The amount that a Patient pays towards the claim/service prior to submission to the carrier or its designee.
Member Suffix / Sequence Number	Uniquely numbers the member within the health insurance contract
Members SIC Code	A code describing the line of work the enrollee is in. Carriers will use Standard Industrial Classification (SIC) code values.
NAICS	See North American Industry Classification System.
National Billing Provider ID	National Provider Identification (NPI) of the Billing Provider
National Council for Prescription Drug Programs (NCPDP)	The Standards Organization for the pharmacy industry.
National Plan ID	Unique identifier as outlined by Centers for Medicare and Medicaid Services (CMS) for Plans.
National Provider Identification (NPI)	A unique identification number for covered health care providers and health plans required under the Health Insurance Portability and Accountability Act (HIPPA) for Administrative Simplification.
National Service Provider ID	National Provider Identification (NPI) of the Servicing Provider.
NCPDP	See National Council for Prescription Drug Programs

Term	Definition
Non Covered Days	The number of inpatient days not covered by the plan under the member's eligibility. See Covered Days.
Non-Covered Amount	An amount that refers to services that were not considered covered under the member's eligibility.
North American Industry Classification System (NAICS)	North American Industry Classification System: a standard classification system used to define businesses and the tasks within a business for statistical analysis, used by Federal statistical agencies for the purpose of collecting, analyzing, and publishing statistical data related to the U.S. business economy
NOT NEEDED:	
NPI	See National Provider Identification
Organization Identification (Org ID)	A DHCFP contact management unique enumeration assigned to any entity to allow for identification of communications between entities. Also acts as a control mechanism and a relationship connector between outside entities.
OrgID	See Organization Identification
P4P	See Pay for Performance
Paid Date	The date that a claim line is actually paid. Date that appears on the check and/or remit and/or explanation of benefits and corresponds to any and all types of payment. This can be the same date as Processed Date.
Patient	An individual that is receiving direct clinical care or oversight of self-care.
Patient Centered Medical Home (PCMH)	An approach to providing comprehensive primary care for children, youth and adults. The PCMH is a health care setting that facilitates partnerships between individual patients, and their personal physicians, and when appropriate, the patient's family
Patient Control Number	This is a unique identifier assigned by the provider for individual encounters of care or claims.
Payer	See Health Care Payer
Payer Claim Control Number	A unique identifier within the payer's system that applies to the entire claim for the life of that claim. Not to be confused with Patient Control Number that originates at the provider site.
Payment	Financial transfer from payer to provider for services rendered to patients, quality maintenance, performance measures or training initiatives.
PBM	See Pharmacy Benefit Manager
PC File	See Pharmacy Claim File
PCMH	See Patient Centered Medical Home
PCP	See Primary Care Physician
PCP Indicator	A MA APCD Flag Indicator that reports a claim line-item as being performed by the patient's Primary Care Physician. See Primary Care Physician

Term	Definition
Pharmacy Benefit Manager (PBM)	A Pharmacy benefit manager (PBM) is a company that administers all or some portion of a drug benefit program of an employer group or health plan.
Pharmacy Claim File (PC File)	A MA APCD File Type for reporting all Paid Pharmacy Claim Lines of a given time period. File accommodates Replacement and Void lines.
Plan Rendering Provider Identifier	Carrier's unique code which identifies for the carrier who or which individual provider cared for the patient for the claim line in question.
Plan Specific Contract Number	Plan assigned contract number. This should be the contract or certificate number for the subscriber and all of his/her dependents.
Point of Service (POS)	A point-of-service (POS) plan is a health maintenance organization (HMO) and a preferred provider organization (PPO) hybrid. POS plans resemble HMOs for in-network services. Services received outside of the network are usually reimbursed in a manner similar to conventional indemnity plans
POS	See Point of Service
PR File	See Product File
Preferred Provider Organization (PPO)	A plan where coverage is provided to participants through a network of selected health care providers (such as hospitals and physicians). The enrollees may go outside the network, but would incur larger costs in the form of higher deductibles, higher coinsurance rates, or non-discounted charges from the providers.
Primary Care Physician (PCP)	A physician who serves as a member's primary contact for health care. The primary care physician provides basic medical services, coordinates and, if required, authorizes referrals to specialists and hospitals.
Primary Insurance Indicator	A MA APCD Flag Indicator that reports if the payer adjudicated a Claim Line as the Primary Payer.
Private Health Care Payer	A carrier authorized to transact accident and health insurance under chapter 175, a nonprofit hospital service corporation licensed under chapter 176A, a nonprofit medical service corporation licensed under chapter 176B, a dental service corporation organized under chapter 176E, an optometric service corporation organized under chapter 176F, a self-insured plan to the extent allowable under federal law governing health care provided by employers to employees, or a health maintenance organization licensed under chapter 176G.
Product	Any offering for sale by a health plan or vendor. It typically describes carrier-based business models such as HMO, PPO but is also synonymous with processing services, network leasing, re-pricing vendors.
Product Enrollment End Date	The date the member enrolled in the product
Product Enrollment Start Date	The date the member dis-enrolled in the product.
Product File (PR File)	A MA APCD file that reports all products that a carrier maintains as a saleable service. Typically these products are listed with the Division of Insurance.
Product Identifier	A unique identifier created by the submitter to each Product offered. It is used to link eligibilities to products and to validate claim adjudication per the product.

Term	Definition
Provider	A health care practitioner, health care facility, health care group, medical product vendor, or pharmacy.
Provider File (PV File)	A MA APCD file containing information on all types of health care provider entities. Typically these are active, contracted providers.
Provider ID	A unique identifier assigned by the carrier or designee and reported in the MA APCD files.
Public Health Care Payer	The Medicaid program established in chapter 118E; any carrier or other entity that contracts with the office of Medicaid or the Commonwealth Health Insurance Connector to pay for or arrange for the purchase of health care services on behalf of individuals enrolled in health coverage programs under Titles XIX or XXI, or under the Commonwealth Care Health Insurance program, including prepaid health plans subject to the provisions of section 28 of chapter 47 of the acts of 1997; the Group Insurance Commission established under chapter 32A; and any city or town with a population of more than 60,000 that has adopted chapter 32B. Also includes Medicare.
PV File	See Provider File
QA	See Quality Assurance
Quality Assurance (QA)	The process of verifying the reliability and accuracy of data within the thresholds set and rationales reported.
Rebate Indicator	A MA APCD Flag Indicator that reports if a pharmacy line was open for any rebate activity.
Referral Indicator	A MA APCD Flag Indicator that reports if a claim line required a referral regardless of its final adjudication.
Reimbursement Form	A form created by a carrier for subscribers / members to submit incurred costs to the carrier that are reimbursable under the benefit plan.
Risk Type	Refers to whether a product was fully-insured or self-insured.
Route of Administration	Indicates how drug is administered. Orally, injection, etc.
Script number	The unique enumerated identifier that appears on a prescription form from a provider.
Self-Insured	A plan offered by employers who directly assume the major/full cost of health insurance for their employees. They may bear the entire risk, or insure against large claims by purchasing stop-loss coverage. The self-insured employers may contract with insurance carriers or third party administrators for claims processing and other administrative services; others are self-administered.
Service Provider Entity Type Qualifier	A MA APCD identifier used to refine a provider reporting into one of two categories, a person, or one of several non-person entity types.
Service Provider Specialty	The specialty of the servicing provider with whom a patient sought care.
Service Rendering Provider	The health care professional that performed the procedure or provided direct patient oversight.
Severity Level	See DRG Level
Single/Multiple Source Indicator	Drug Source Indicator. An identifier used to report pharmacy product streams.
Site of Service - on NSF/CMS 1500 Claims	Place of Service Code as used on Professional Claims. This is a two-digit code that reports where services were

Term	Definition
	rendered by a health care professional.
Special Coverage	A MA APCD identifier used to refine eligibility with non-traditional coverage models to explain covered services and networks for this population. Valid choices are Commonwealth Care, Health Safety Net or N/A if not applicable.
Submission Guide	The document that sets forth the required data file format, record specifications, data elements, definitions, code tables and edit specifications.
Submitter	Any entity that has been registered with the Division as a data submitter. This can be health plans, TPAs, PBMs, DBAs, or any entity approved to submit data on behalf of another entity; requires registration with the Division. See Organization ID.
Subscriber	The subscriber is the insurance policy holder. The individual that has opted into and pays a premium for health insurance benefits under a defined policy. In some instances, the subscriber can be the Employer, or a non-related individual in cases of personal injury.
Third-Party Administrator (TPA)	Any person or entity that receives or collects charges, contributions, or premiums for, or adjusts or settles claims for, Massachusetts residents on behalf of a plan sponsor, health care services plan, nonprofit hospital or medical service organization, health maintenance organization, or insurer.
Third-Party Liability (TPL)	Refers to the coverage provided by a specific carrier for certain risks; typically work, auto, personal injury related.
Threshold Reduction	A process of the APCD Variance Request that a submitter performs to reduce the percentage of quality data that they must submit. This is performed prior to submitting a file to insure that A-Level Thresholds are met to pass the file into Quality Assurance.
TPA	See Third-Party Administrator.
TPL	See Third-Party Liability.
Type of Bill - on Facility Claims	This is a two-digit code that reports the type of facility in which services were rendered.
UB04	See Universal Billing Form 04.
Unemployed	An individual that does not hold a paying position with a company.
Universal Billing Form 04	A standard billing form created by the National Universal Billing Committee for Facility Claims. The 04 refers to the last updated version of the claim format. It is typically a paper form but electronic versions of it exist.
Variance	See Variance Request
Variance Request (VR)	A request to the Division that explains why an organization cannot submit a field (or fields), meet a threshold (or thresholds), or submit a file (or files). A form developed by the MA APCD that defines base reporting percentages for all data elements on all filing types, where the submitter may disclose reasons for not meeting base-percentage reporting, and request a threshold reduction to percentages that can be met.
Version Number	Version number of this claim service line. An enumeration process required by the MA APCD Claims Files to insure that the most recent line(s) of any given claim are used in that claims analysis at time of reporting.

Term	Definition
Voided Claims	Claim lines filed that will be excluded from analysis (i.e. Claims that were deemed not eligible for payment, after initial payment was made, due to various qualifying conditions.) In the MA APCD System, these lines are matched to their opposite and last version from a previous submission and are not used in analysis at time of reporting.
Withhold Amount	The amount paid to the provider for this Claim Line if the provider qualifies / meets the agreed upon performance guarantees.

Appendix 2: External Code Sources

APCD: External Code Sources		
1	**Countries**	American National Standards Institute 11 West 42nd Street, 13th Floor New York, NY 10036
2	**States and Other Areas of the US**	U.S. Postal Service National Information Data Center P.O. Box 2977 Washington, DC 20013
3	**Zip Codes**	U.S. Postal Service Washington, DC 20260
4	**Centers for Medicare and Medicaid Services National Provider Identifier**	Centers for Medicare and Medicaid Services Office of Financial Management Division of Provider/Supplier Enrollment C4-10-07 7500 Security Boulevard Baltimore, MD 21244-1850
5	**International Classification of Diseases Clinical Modification, 9th Revision**	U.S. Government Printing Office P.O. Box 371954 Pittsburgh, PA 15250
6	**International Classification of Diseases Clinical Modification, 10th Revision**	National Center for Health Statistics 3311 Toledo Road Hyattsville, MD 20782
7	**Healthcare Common Procedural Coding System**	Centers for Medicare and Medicaid Services 7500 Security Boulevard Baltimore, MC 21244
8	**American Dental Association**	Salable Materials American Dental Association 211 East Chicago Avenue Chicago, IL 60611-2678
9	**Place of Service Codes for Professional Claims**	Centers for Medicare and Medicaid Services CMSO, Mail Stop S2-01-16 7500 Security Blvd Baltimore, MD 21244-1850

APCD: External Code Sources		
10	**National Uniform Billing Committee (NUBC) Codes**	National Uniform Billing Committee American Hospital Association One North Franklin Chicago, IL 60606
11	**Diagnosis Related Group Number (DRG)**	Superintendent of Documents U.S. Government Printing Office Washington, DC 20402
12	**National Drug Code Format**	Federal Drug Listing Branch HFN-315 5600 Fishers Lane Rockville, MD 20857
13	**Health Care Provider Taxonomy**	The National Uniform Claim Committee c/o American Medical Association 515 North State Street Chicago, IL 60610
14	**Claim Adjustment Reason Codes**	Blue Cross / Blue Shield Association Interplan Teleprocessing Services Division 676 N. St. Clair Street Chicago, IL 60611
15	**North American Industry Classification System (NAICS)**	National Technical Information Service Alexandria, VA 22312

Appendix 3: Release File Column Names

Release File Column Names: Public Release Elements					
FILE	**P/R**	**Element Order**	**Element**	**Data Element Name**	**Release File Column Name**
PR	P	1	PR006	Product Benefit Type	ProductBenefitType
PR	P	2	PR008	Risk Type	RiskType
PR	P	3	PR011	Product Active Flag	ProductActiveFlag
PR	P	4	PR012	Annual Per Person Deductible Code	AnnualPerPersonDeductibleCode
PR	P	5	PR013	Annual Per Family Deductible Code	AnnualPerFamilyDeductibleCode
PR	P	6	PR014	Coordinated Care model	CoordinatedCareModel
PR	P	7	PR899	Record Type	RecordType
PR	P	8	HD002 / PR001	Payer / Product ID	HashPayerProductID
PR	P	9	Derived by DHCFP	Unique Record ID	PublicUseID
ME	P	1	ME003	Insurance Type Code/Product	InsuranceTypeCodeProduct
ME	P	2	ME007	Coverage Level Code	CoverageLevelCode
ME	P	3	ME013	Member Gender	MemberGender
ME	P	4	ME014/Year	Member Birth Year	MemberDateofBirthYear
ME	P	5	ME016	Member State or Province	MemberStateorProvince
ME	P	6	ME018	Medical Coverage	MedicalCoverage
ME	P	7	ME019	Prescription Drug Coverage	PrescriptionDrugCoverage
ME	P	8	ME020	Dental Coverage	DentalCoverage
ME	P	9	ME021	Race 1	Race1
ME	P	10	ME022	Race 2	Race2
ME	P	11	ME023	Other Race	OtherRace
ME	P	12	ME024	Hispanic Indicator	HispanicIndicator
ME	P	13	ME025	Ethnicity 1	Ethnicity1

Release File Column Names: Public Release Elements					
FILE	**P/R**	**Element Order**	**Element**	**Data Element Name**	**Release File Column Name**
ME	P	14	ME026	Ethnicity 2	Ethnicity2
ME	P	15	ME027	Other Ethnicity	OtherEthnicity
ME	P	16	ME028	Primary Insurance Indicator	PrimaryInsuranceIndicator
ME	P	17	ME029	Coverage Type	CoverageType
ME	P	18	ME030	Market Category Code	MarketCategoryCode
ME	P	19	ME033	Member language preference	MemberLanguagePreference
ME	P	20	ME034	Member language preference -Other	MemberLanguagePreferenceOther
ME	P	21	ME035	Health Care Home Assigned Flag	HealthCareHomeAssignedFlag
ME	P	22	ME037	Health Care Home Tax ID Number	HashHealthCareHomeTaxIDNumber
ME	P	23	ME038	Health Care Home National Provider ID	HashHealthCareHomeNationalProviderID
ME	P	24	ME039	Health Care Home Name	HashHealthCareHomeName
ME	P	25	ME047	Member PCP Effective Date	MemberPCPEffectiveDate
ME	P	26	ME048	Member PCP Termination Date	MemberPCPTerminationDate
ME	P	27	ME049	Member Deductible	MemberDeductible
ME	P	28	ME050	Member Deductible Used	MemberDeductibleUsed
ME	P	29	ME051	Behavioral Health Benefit Flag	BehavioralHealthBenefitFlag
ME	P	30	ME052	Laboratory Benefit Flag	LaboratoryBenefitFlag
ME	P	31	ME053	Disease Management Enrollee Flag	DiseaseManagementEnrolleeFlag
ME	P	32	ME059	Disability Indicator Flag	DisabilityIndicatorFlag
ME	P	33	ME061	Student Status	StudentStatus
ME	P	34	ME062	Marital Status	MaritalStatus
ME	P	35	ME063	Benefit Status	BenefitStatus
ME	P	36	ME064	Employee Type	EmployeeType
ME	P	37	ME066	COBRA Status	COBRAStatus
ME	P	38	ME073	Fully insured member	FullyInsuredMember

Release File Column Names: Public Release Elements					
FILE	**P/R**	**Element Order**	**Element**	**Data Element Name**	**Release File Column Name**
ME	P	39	ME074	Interpreter	Interpreter
ME	P	40	ME077	Members SIC Code	HashMembersSICCode
ME	P	41	ME081	Medicare Code	MedicareCode
ME	P	42	ME109	Subscriber State or Province	SubscriberStateorProvince
ME	P	43	ME111	Medical Deductible	MedicalDeductible
ME	P	44	ME112	Pharmacy Deductible	PharmacyDeductible
ME	P	45	ME113	Medical and Pharmacy Deductible	MedicalandPharmacyDeductible
ME	P	46	ME114	Behavioral Health Deductible	BehavioralHealthDeductible
ME	P	47	ME115	Dental Deductible	DentalDeductible
ME	P	48	ME116	Vision Deductible	VisionDeductible
ME	P	49	ME118	Vision Benefit	VisionBenefit
ME	P	50	ME899	Record Type	RecordType
ME	P	51	ME001 / ME036	Health Care Home Number	HashPayerHealthCareHomeNumber
ME	P	52	ME001 / ME040	Product ID Number	HashPayerProductIDNumber
ME	P	53	ME001 / ME107	Payer / CarrierSpecificUniqueMemberID	HashPayerCarrierSpecificUniqueMemberID
ME	P	54	ME001 / ME117	Payer / CarrierSpecificUniqueSubscriberID	HashPayerCarrierSpecificUniqueSubscriberID
ME	P	55	Derived by DHCFP	Unique Record ID	PublicUseID
MC	P	1	MC005	Line Counter	LineCounter
MC	P	2	MC005A	Version Number	VersionNumber
MC	P	3	MC012	Member Gender	MemberGender
MC	P	4	MC013/Year	Member Birth Year	MemberDateofBirthYear
MC	P	5	MC015	Member State or Province	MemberStateorProvince
MC	P	6	MC020	Admission Type	AdmissionType
MC	P	7	MC021	Admission Source	AdmissionSource
MC	P	8	MC023	Discharge Status	DischargeStatus

Release File Column Names: Public Release Elements					
FILE	**P/R**	**Element Order**	**Element**	**Data Element Name**	**Release File Column Name**
MC	P	9	MC026	National Service Provider ID	HashNationalServiceProviderID
MC	P	10	MC027	Service Provider Entity Type Qualifier	ServiceProviderEntityTypeQualifier
MC	P	11	MC028	Service Provider First Name	ServiceProviderFirstName
MC	P	12	MC029	Service Provider Middle Name	ServiceProviderMiddleName
MC	P	13	MC030	Servicing Provider Last Name or Organization Name	ServiceProviderLastNameorOrganizationName
MC	P	14	MC031	Service Provider Suffix	ServiceProviderSuffix
MC	P	15	MC032	Service Provider Specialty	ServiceProviderSpecialty
MC	P	16	MC033	Service Provider City Name	ServiceProviderCityName
MC	P	17	MC034	Service Provider State	ServiceProviderState
MC	P	18	MC035	Service Provider ZIP Code	ServiceProviderZIPCode
MC	P	19	MC036	Type of Bill - on Facility Claims	TypeofBillOnFacilityClaims
MC	P	20	MC037	Site of Service - on NSF/CMS 1500 Claims	SiteofServiceOnNSFCMS1500Claims
MC	P	21	MC038	Claim Status	ClaimStatus
MC	P	22	MC039	Admitting Diagnosis	AdmittingDiagnosis
MC	P	23	MC040	E-Code	ECode
MC	P	24	MC041	Principal Diagnosis	PrincipalDiagnosis
MC	P	25	MC042	Other Diagnosis - 1	OtherDiagnosis1
MC	P	26	MC043	Other Diagnosis - 2	OtherDiagnosis2
MC	P	27	MC044	Other Diagnosis - 3	OtherDiagnosis3
MC	P	28	MC045	Other Diagnosis - 4	OtherDiagnosis4
MC	P	29	MC046	Other Diagnosis - 5	OtherDiagnosis5
MC	P	30	MC047	Other Diagnosis - 6	OtherDiagnosis6
MC	P	31	MC048	Other Diagnosis - 7	OtherDiagnosis7
MC	P	32	MC049	Other Diagnosis - 8	OtherDiagnosis8
MC	P	33	MC050	Other Diagnosis - 9	OtherDiagnosis9

Release File Column Names: Public Release Elements					
FILE	**P/R**	**Element Order**	**Element**	**Data Element Name**	**Release File Column Name**
MC	P	34	MC051	Other Diagnosis - 10	OtherDiagnosis10
MC	P	35	MC052	Other Diagnosis - 11	OtherDiagnosis11
MC	P	36	MC053	Other Diagnosis - 12	OtherDiagnosis12
MC	P	37	MC054	Revenue Code	RevenueCode
MC	P	38	MC055	Procedure Code	ProcedureCode
MC	P	39	MC056	Procedure Modifier - 1	ProcedureModifier1
MC	P	40	MC057	Procedure Modifier - 2	ProcedureModifier2
MC	P	41	MC058	ICD9-CM Procedure Code	ICD9CMProcedureCode
MC	P	42	MC061	Quantity	Quantity
MC	P	43	MC062	Charge Amount	ChargeAmount
MC	P	44	MC063	Paid Amount	PaidAmount
MC	P	45	MC064	Prepaid Amount	PrepaidAmount
MC	P	46	MC065	Copay Amount	CopayAmount
MC	P	47	MC066	Coinsurance Amount	CoinsuranceAmount
MC	P	48	MC067	Deductible Amount	DeductibleAmount
MC	P	49	MC070	Service Provider Country Code	ServiceProviderCountryCode
MC	P	50	MC071	DRG	DRG
MC	P	51	MC072	DRG Version	DRGVersion
MC	P	52	MC073	APC	APC
MC	P	53	MC074	APC Version	APCVersion
MC	P	54	MC075	Drug Code	DrugCode
MC	P	55	MC077	National Billing Provider ID	HashNationalBillingProviderID
MC	P	56	MC078	Billing Provider Last Name or Organization Name	BillingProviderLastNameOrOrganizationName
MC	P	57	MC081	Capitated Encounter Flag	CapitatedEncounterFlag
MC	P	58	MC083	Other ICD-9-CM Procedure Code - 1	OtherICD9CMProcedureCode1

Release File Column Names: Public Release Elements					
FILE	**P/R**	**Element Order**	**Element**	**Data Element Name**	**Release File Column Name**
MC	P	59	MC084	Other ICD-9-CM Procedure Code - 2	OtherICD9CMProcedureCode2
MC	P	60	MC085	Other ICD-9-CM Procedure Code - 3	OtherICD9CMProcedureCode3
MC	P	61	MC086	Other ICD-9-CM Procedure Code - 4	OtherICD9CMProcedureCode4
MC	P	62	MC087	Other ICD-9-CM Procedure Code - 5	OtherICD9CMProcedureCode5
MC	P	63	MC088	Other ICD-9-CM Procedure Code - 6	OtherICD9CMProcedureCode6
MC	P	64	MC089	Paid Date	PaidDate
MC	P	65	MC090	LOINC Code	LOINCCode
MC	P	66	MC092	Covered Days	CoveredDays
MC	P	67	MC093	Non Covered Days	NonCoveredDays
MC	P	68	MC094	Type of Claim	TypeofClaim
MC	P	69	MC095	Coordination of Benefits/TPL Liability Amount	CoordinationOfBenefitsTPLLiabilityAmount
MC	P	70	MC096	Other Insurance Paid Amount	OtherInsurancePaidAmount
MC	P	71	MC097	Medicare Paid Amount	MedicarePaidAmount
MC	P	72	MC099	Non-Covered Amount	NonCoveredAmount
MC	P	73	MC108	Procedure Modifier - 3	ProcedureModifier3
MC	P	74	MC109	Procedure Modifier - 4	ProcedureModifier4
MC	P	75	MC111	Diagnostic Pointer	DiagnosticPointer
MC	P	76	MC113	Payment Arrangement Type	PaymentArrangementType
MC	P	77	MC114	Excluded Expenses	ExcludedExpenses
MC	P	78	MC115	Medicare Indicator	MedicareIndicator
MC	P	79	MC116	Withhold Amount	WithholdAmount
MC	P	80	MC117	Authorization Needed	AuthorizationNeeded
MC	P	81	MC118	Referral Indicator	ReferralIndicator
MC	P	82	MC119	PCP Indicator	PCPIndicator
MC	P	83	MC120	DRG Level	DRGLevel

Release File Column Names: Public Release Elements					
FILE	**P/R**	**Element Order**	**Element**	**Data Element Name**	**Release File Column Name**
MC	P	84	MC122	Global Payment Flag	GlobalPaymentFlag
MC	P	85	MC123	Denied Flag	DeniedFlag
MC	P	86	MC126	Accident Indicator	AccidentIndicator
MC	P	87	MC127	Family Planning Indicator	FamilyPlanningIndicator
MC	P	88	MC128	Employment Related Indicator	EmploymentRelatedIndicator
MC	P	89	MC129	EPSDT Indicator	EPSDTIndicator
MC	P	90	MC130	Procedure Code Type	ProcedureCodeType
MC	P	91	MC131	InNetwork Indicator	InNetworkIndicator
MC	P	92	MC132	Service Class	ServiceClass
MC	P	93	MC136	Discharge Diagnosis	DischargeDiagnosis
MC	P	94	MC138	Claim Line Type	ClaimLineType
MC	P	95	MC899	Record Type	RecordType
MC	P	96	MC001 / MC024	Payer / Service Provider Number	HashPayerServiceProviderNumber
MC	P	97	MC001 / MC032	Payer / Service Provider Specialty	HashPayerServiceProviderSpecialty
MC	P	98	MC001 / MC076	Payer / Billing Provider Number	HashPayerBillingProviderNumber
MC	P	99	MC001 / MC079	Payer / Product ID Number	HashPayerProductIDNumber
MC	P	100	MC001 / MC100	Payer / Delegated Benefit Administrator Organization ID	HashPayerDelegatedBenefitAdministratorOrganizationID
MC	P	101	MC001 / MC112	Payer / Referring Provider ID	HashPayerReferringProviderID
MC	P	102	MC001 / MC125	Payer / Attending Provider	HashPayerAttendingProvider
MC	P	103	MC001 / MC132	Payer / Service Class	HashPayerServiceClass
MC	P	104	MC001 / MC134	Payer / Plan Rendering Provider Identifier	HashPayerPlanRenderingProviderIdentifier
MC	P	105	MC001 / MC135	Payer / Provider Location	HashPayerProviderLocation
MC	P	106	MC001 / MC137	Payer / CarrierSpecificUniqueMemberID	HashPayerCarrierSpecificUniqueMemberID
MC	P	107	MC001 / MC141	Payer / CarrierSpecificUniqueSubscriberID	HashPayerCarrierSpecificUniqueSubscriberID
MC	P	108	Derived by DHCFP	Final Version Flag	HighestVersion

Release File Column Names: Public Release Elements					
FILE	**P/R**	**Element Order**	**Element**	**Data Element Name**	**Release File Column Name**
MC	P	109	Derived by DHCFP	Unique Record ID	PublicUseID
DC	P	1	DC005	Line Counter	LineCounter
DC	P	2	DC005A	Version Number	VersionNumber
DC	P	3	DC012	Member Gender	MemberGender
DC	P	4	DC013/Year	Member Birth Year	MemberDateofBirthYear
DC	P	5	DC015	Member State or Province	MemberStateorProvince
DC	P	6	DC020	National Service Provider ID	HashNationalServiceProviderID
DC	P	7	DC021	Service Provider Entity Type Qualifier	ServiceProviderEntityTypeQualifier
DC	P	8	DC022	Service Provider First Name	ServiceProviderFirstName
DC	P	9	DC023	Service Provider Middle Name	ServiceProviderMiddleName
DC	P	10	DC024	Service Provider Last Name or Organization Name	ServiceProviderLastNameorOrganizationName
DC	P	11	DC026	Service Provider Specialty	ServiceProviderSpecialty
DC	P	12	DC027	Service Provider City Name	ServiceProviderCityName
DC	P	13	DC028	Service Provider State	ServiceProviderState
DC	P	14	DC029	Service Provider ZIP Code	ServiceProviderZIPCode
DC	P	15	DC030	Facility Type - Professional	FacilityTypeProfessional
DC	P	16	DC031	Claim Status	ClaimStatus
DC	P	17	DC032	CDT Code	CDTCode
DC	P	18	DC033	Procedure Modifier - 1	ProcedureModifier1
DC	P	19	DC034	Procedure Modifier - 2	ProcedureModifier2
DC	P	20	DC037	Charge Amount	ChargeAmount
DC	P	21	DC038	Paid Amount	PaidAmount
DC	P	22	DC039	Copay Amount	CopayAmount
DC	P	23	DC040	Coinsurance Amount	CoinsuranceAmount
DC	P	24	DC041	Deductible Amount	DeductibleAmount

Release File Column Names: Public Release Elements					
FILE	**P/R**	**Element Order**	**Element**	**Data Element Name**	**Release File Column Name**
DC	P	25	DC045	Paid Date	PaidDate
DC	P	26	DC047	Tooth Number/Letter	ToothNumberLetter
DC	P	27	DC048	Dental Quadrant	DentalQuadrant
DC	P	28	DC049	Tooth Surface	ToothSurface
DC	P	29	DC059	Claim Line Type	ClaimLineType
DC	P	30	DC899	Record Type	RecordType
DC	P	31	DC001 / DC018	Payer / Service Provider Number	HashPayerServiceProviderNumber
DC	P	32	DC001 / DC025	Payer / Delegated Benefit Administrator Organization ID	HashPayerDelegatedBenefitAdministratorOrganizationID
DC	P	33	DC001 / DC026	Payer / Service Provider Specialty	HashPayerServiceProviderSpecialty
DC	P	34	DC001 / DC042	Payer / Product ID Number	HashPayerProductIDNumber
DC	P	35	DC001 / DC056	Payer / CarrierSpecificUniqueMemberID	HashPayerCarrierSpecificUniqueMemberID
DC	P	36	DC001 / DC057	Payer / CarrierSpecificUniqueSubscriberID	HashPayerCarrierSpecificUniqueSubscriberID
DC	P	37	Derived by DHCFP	Final Version Flag	HighestVersion
DC	P	38	Derived by DHCFP	Unique Record ID	PublicUseID
PC	P	1	PC005	Line Counter	LineCounter
PC	P	2	PC005A	Version Number	VersionNumber
PC	P	3	PC012	Member Gender	MemberGender
PC	P	4	PC013	Member Birth Year	MemberDateofBirthYear
PC	P	5	PC015	Member State	MemberState
PC	P	6	PC020	Pharmacy Name	PharmacyName
PC	P	7	PC021	National Pharmacy ID Number	HashNationalPharmacyIDNumber
PC	P	8	PC022	Pharmacy Location City	PharmacyLocationCity
PC	P	9	PC023	Pharmacy Location State	PharmacyLocationState
PC	P	10	PC024	Pharmacy ZIP Code	PharmacyZIPCode
PC	P	11	PC024A	Pharmacy Country Code	PharmacyCountryCode

Release File Column Names: Public Release Elements					
FILE	**P/R**	**Element Order**	**Element**	**Data Element Name**	**Release File Column Name**
PC	P	12	PC025	Claim Status	ClaimStatus
PC	P	13	PC026	Drug Code	DrugCode
PC	P	14	PC027	Drug Name	DrugName
PC	P	15	PC028	New Prescription or Refill	NewPrescriptionOrRefill
PC	P	16	PC029	Generic Drug Indicator	GenericDrugIndicator
PC	P	17	PC030	Dispense as Written Code	DispenseasWrittenCode
PC	P	18	PC031	Compound Drug Indicator	CompoundDrugIndicator
PC	P	19	PC033	Quantity Dispensed	QuantityDispensed
PC	P	20	PC034	Days Supply	DaysSupply
PC	P	21	PC035	Charge Amount	ChargeAmount
PC	P	22	PC036	Paid Amount	PaidAmount
PC	P	23	PC037	Ingredient Cost/List Price	IngredientCostListPrice
PC	P	24	PC038	Postage Amount Claimed	PostageAmountClaimed
PC	P	25	PC039	Dispensing Fee	DispensingFee
PC	P	26	PC040	Copay Amount	CopayAmount
PC	P	27	PC041	Coinsurance Amount	CoinsuranceAmount
PC	P	28	PC042	Deductible Amount	DeductibleAmount
PC	P	29	PC044	Prescribing Physician First Name	PrescribingPhysicianFirstName
PC	P	30	PC045	Prescribing Physician Middle Name	PrescribingPhysicianMiddleName
PC	P	31	PC046	Prescribing Physician Last Name	PrescribingPhysicianLastName
PC	P	32	PC048	Prescribing Physician NPI	HashPrescribingPhysicianNPI
PC	P	33	PC049	Prescribing Physician Plan Number	HashPrescribingPhysicianPlanNumber
PC	P	34	PC050	Prescribing Physician License Number	HashPrescribingPhysicianLicenseNumber
PC	P	35	PC053	Prescribing Physician City	PrescribingPhysicianCity
PC	P	36	PC054	Prescribing Physician State	PrescribingPhysicianState

Release File Column Names: Public Release Elements					
FILE	**P/R**	**Element Order**	**Element**	**Data Element Name**	**Release File Column Name**
PC	P	37	PC055	Prescribing Physician Zip	PrescribingPhysicianZip
PC	P	38	PC057	Mail Order pharmacy	MailOrderPharmacy
PC	P	39	PC060	Single/Multiple Source Indicator	SingleMultipleSourceIndicator
PC	P	40	PC063	Paid Date	PaidDate
PC	P	41	PC066	Other Insurance Paid Amount	OtherInsurancePaidAmount
PC	P	42	PC069	Member Self Pay Amount	MemberSelfPayAmount
PC	P	43	PC070	Rebate Indicator	RebateIndicator
PC	P	44	PC071	State Sales Tax	StateSalesTax
PC	P	45	PC073	Formulary Code	FormularyCode
PC	P	46	PC074	Route of Administration	RouteOfAdministration
PC	P	47	PC075	Drug Unit of Measure	DrugUnitOfMeasure
PC	P	48	PC110	Claim Line Type	ClaimLineType
PC	P	49	PC899	Record Type	RecordType
PC	P	50	PC001 / PC018	Payer / Pharmacy Number	HashPayerPharmacyNumber
PC	P	51	PC001 / PC043	Payer / Prescribing ProviderID	HashPayerPrescribingProviderID
PC	P	52	PC001 / PC056	Payer / Product ID Number	HashPayerProductIDNumber
PC	P	53	PC001 / PC059	Payer / Recipient PCP ID	HashPayerRecipientPCPID
PC	P	54	PC001 / PC072	Payer / Delegated Benefit Administrator Organization ID	HashPayerDelegatedBenefitAdministratorOrganizationID
PC	P	55	PC001 / PC107	Payer / CarrierSpecificUniqueMemberID	HashPayerCarrierSpecificUniqueMemberID
PC	P	56	PC001 / PC108	Payer / CarrierSpecificUniqueSubscriberID	HashPayerCarrierSpecificUniqueSubscriberID
PC	P	57	Derived by DHCFP	Final Version Flag	HighestVersion
PC	P	58	Derived by DHCFP	Unique Record ID	PublicUseID
PV	P	1	PV006	License Id	HashLicenseId
PV	P	2	PV008	Last Name	LastName
PV	P	3	PV009	First Name	FirstName

Release File Column Names: Public Release Elements					
FILE	**P/R**	**Element Order**	**Element**	**Data Element Name**	**Release File Column Name**
PV	P	4	PV010	Middle Initial	MiddleInitial
PV	P	5	PV011	Suffix	Suffix
PV	P	6	PV012	Entity Name	EntityName
PV	P	7	PV013	Entity Code	EntityCode
PV	P	8	PV014	Gender Code	GenderCode
PV	P	9	PV018	City Name	CityName
PV	P	10	PV019	State Code	StateCode
PV	P	11	PV020	Country Code	CountryCode
PV	P	12	PV021	Zip Code	ZipCode
PV	P	13	PV022	Taxonomy	Taxonomy
PV	P	14	PV023	Mailing Street Address1 Name	MailingStreetAddress1Name
PV	P	15	PV024	Mailing Street Address2 Name	MailingStreetAddress2Name
PV	P	16	PV025	Mailing City Name	MailingCityName
PV	P	17	PV026	Mailing State Code	MailingStateCode
PV	P	18	PV027	Mailing Country Code	MailingCountryCode
PV	P	19	PV028	Mailing Zip Code	MailingZipCode
PV	P	20	PV029	Provider Type Code	ProviderTypeCode
PV	P	21	PV030	Primary Specialty Code	PrimarySpecialtyCode
PV	P	22	PV034	ProviderIDCode	ProviderIDCode
PV	P	23	PV037	Begin Date	BeginDate
PV	P	24	PV038	End Date	EndDate
PV	P	25	PV039	National Provider ID	HashNationalProviderID
PV	P	26	PV040	National Provider2 ID	HashNationalProvider2ID
PV	P	27	PV042	Secondary Specialty2 Code	SecondarySpecialty2Code
PV	P	28	PV043	Secondary Specialty3 Code	SecondarySpecialty3Code

Release File Column Names: Public Release Elements					
FILE	**P/R**	**Element Order**	**Element**	**Data Element Name**	**Release File Column Name**
PV	P	29	PV044	Secondary Specialty4 Code	SecondarySpecialty4Code
PV	P	30	PV045	P4PFlag	P4PFlag
PV	P	31	PV046	NonClaimsFlag	NonClaimsFlag
PV	P	32	PV047	Uses Electronic Medical Records	UsesElectronicMedicalRecords
PV	P	33	PV048	EMR Vendor	EMRVendor
PV	P	34	PV049	Accepting New Patients	AcceptingNewPatients
PV	P	35	PV050	Offers e-Visits	OfferseVisits
PV	P	36	PV052	Has multiple offices	Hasmultipleoffices
PV	P	37	PV055	PCP Flag	PCPFlag
PV	P	38	PV057	Provider Telephone	ProviderTelephone
PV	P	39	PV058	Delegated Provider Record Flag	DelegatedProviderRecordFlag
PV	P	40	PV060	Office Type	OfficeType
PV	P	41	PV061	Prescribing Provider	PrescribingProvider
PV	P	42	PV062	Provider Affiliation Start Date	ProviderAffiliationStartDate
PV	P	43	PV063	Provider Affiliation End Date	ProviderAffiliationEndDate
PV	P	44	PV064	PPO Indicator	PPOIndicator
PV	P	45	PV899	Record Type	RecordType
PV	P	46	PV001 / PV002	Payer/Plan Provider ID	HashPayerPlanProviderID
PV	P	47	PV001 / PV029	Payer/Provider Type Code	HashPayerProviderTypeCode
PV	P	48	PV001 / PV030	Payer/Primary Specialty Code	HashPayerPrimarySpecialtyCode
PV	P	49	PV001 / PV042	Payer/Secondary Specialty2 Code	HashPayerSecondarySpecialty2Code
PV	P	50	PV001 / PV043	Payer/Secondary Specialty3 Code	HashPayerSecondarySpecialty3Code
PV	P	51	PV001 / PV044	Payer/Secondary Specialty4 Code	HashPayerSecondarySpecialty4Code
PV	P	52	PV001 / PV054	Payer/Medical/Healthcare Home ID	HashPayerMedicalHealthcareHomeID
PV	P	53	PV001 / PV056	Payer/Provider Affiliation	HashPayerProviderAffiliation

Release File Column Names: Public Release Elements					
FILE	**P/R**	**Element Order**	**Element**	**Data Element Name**	**Release File Column Name**
PV	P	54	Derived by DHCFP	Unique Record ID	PublicUseID

Release File Column Names: Restricted Release Elements					
FILE	**P/R**	**Element Order**	**Element**	**Data Element Name**	**Release File Column Name**
PR	R	1	PR001	Product ID	HashProductID
PR	R	2	HD002	Payer	HashPayer
PR	R	3	PR002	Product Name	HashProductName
PR	R	4	PR003	Carrier License Type	HashCarrierLicenseType
PR	R	5	PR004	Product Line of Business Model	ProductLineofBusinessModel
PR	R	6	PR005	Insurance Plan Market	InsurancePlanMarket
PR	R	7	PR007	Other Product Benefit Description	HashOtherProductBenefitDescription
PR	R	8	PR009	Product Start Date	ProductStartDate
PR	R	9	PR010	Product End Date	ProductEndDate
PR	R	10	Derived by DHCFP	Unique Record ID	PublicUseID
ME	R	1	ME001	Payer	HashPayer
ME	R	2	ME002	National Plan ID	HashNationalPlanID
ME	R	3	ME006	Insured Group or Policy Number	HashInsuredGrouporPolicyNumber
ME	R	4	ME012	Individual Relationship Code	IndividualRelationshipCode
ME	R	5	ME014	Member Birth Month	MemberDateofBirthMonth
ME	R	6	ME015	Member City Name	MemberCityName
ME	R	7	ME017	Member ZIP code (first 3 digits)	First3MemberZip
ME	R	8	ME031	Special Coverage	SpecialCoverage
ME	R	9	ME036	Health Care Home Number	HashHealthCareHomeNumber
ME	R	10	ME040	Product ID Number	HashProductIDNumber

Release File Column Names: Restricted Release Elements					
FILE	**P/R**	**Element Order**	**Element**	**Data Element Name**	**Release File Column Name**
ME	R	11	ME041	Product Enrollment Start Date	ProductEnrollmentStartDate
ME	R	12	ME042	Product Enrollment End Date	ProductEnrollmentEndDate
ME	R	13	ME046	Member PCP ID	HashMemberPCPID
ME	R	14	ME075	NewMMISID	HashNewMMISID
ME	R	15	ME076	Member rating category	MemberRatingCategory
ME	R	16	ME079	Recipient Identification Number (MassHealth only)	HashRecipientIdentificationNumber
ME	R	17	ME080	Recipient Historical Number (MassHealth only)	HashRecipientHistoricalNumber
ME	R	18	ME107	CarrierSpecificUniqueMemberID	HashCarrierSpecificUniqueMemberID
ME	R	19	ME108	Subscriber City Name	SubscriberCityName
ME	R	20	ME110	Subscriber ZIP code (first 3 digits)	First3SubscriberZip
ME	R	21	ME117	CarrierSpecificUniqueSubscriberID	HashCarrierSpecificUniqueSubscriberID
ME	R	22	ME001 / ME046	Payer / Member PCP ID	HashPayerMemberPCPID
ME	R	23	ME001 / ME076	Payer / Member rating category	HashPayerMemberRatingCategory
ME	R	24	Derived by DHCFP	Unique Record ID	PublicUseID
MC	R	1	MC001	Payer	HashPayer
MC	R	2	MC002	National Plan ID	HashNationalPlanID
MC	R	3	MC003	Insurance Type Code/Product	HashInsuranceTypeCodeProduct
MC	R	4	MC004	Payer Claim Control Number	HashPayerClaimControlNumber
MC	R	5	MC006	Insured Group or Policy Number	HashInsuredGrouporPolicyNumber
MC	R	6	MC011	Individual Relationship Code	IndividualRelationshipCode
MC	R	7	MC013	Member Birth Month	MemberDateofBirthMonth
MC	R	8	MC014	Member City Name	MemberCityName
MC	R	9	MC016	Member ZIP code (first 3 digits)	MemberZIpCodeFirst3Digits
MC	R	10	MC017	Date Service Approved (AP Date)	DateServiceApprovedAPDate
MC	R	11	MC018	Admission Date	AdmissionDate

Release File Column Names: Restricted Release Elements					
FILE	**P/R**	**Element Order**	**Element**	**Data Element Name**	**Release File Column Name**
MC	R	12	MC018	Admission Month	AdmissionDateMonth
MC	R	13	MC018	Admission Year	AdmissionDateYear
MC	R	14	MC019	Admission Hour	AdmissionHour
MC	R	15	MC022	Discharge Hour	DischargeHour
MC	R	16	MC024	Service Provider Number	HashServiceProviderNumber
MC	R	17	MC025	Service Provider Tax ID Number	HashServiceProviderTaxIDNumber
MC	R	18	MC059	Date of Service - From	DateofServiceFrom
MC	R	19	MC059	Date of Service - From Month	DateofServiceFromMonth
MC	R	20	MC059	Date of Service - From Year	DateofServiceFromYear
MC	R	21	MC060	Date of Service - To	DateofServiceTo
MC	R	22	MC060	Date of Service - To Month	DateofServiceToMonth
MC	R	23	MC060	Date of Service - To Year	DateofServiceToYear
MC	R	24	MC068	Patient Control Number	HashPatientControlNumber
MC	R	25	MC069	Discharge Date	DischargeDate
MC	R	26	MC069	Discharge Month	DischargeDateMonth
MC	R	27	MC069	Discharge Year	DischargeDateYear
MC	R	28	MC076	Billing Provider Number	HashBillingProviderNumber
MC	R	29	MC079	Product ID Number	HashProductIDNumber
MC	R	30	MC080	Reason for Adjustment	HashReasonforAdjustment
MC	R	31	MC098	Allowed amount	AllowedAmount
MC	R	32	MC100	Delegated Benefit Administrator Organization ID	HashDelegatedBenefitAdministratorOrganizationID
MC	R	33	MC110	Claim Processed Date	ClaimProcessedDate
MC	R	34	MC112	Referring Provider ID	HashReferringProviderID
MC	R	35	MC124	Denial Reason	HashDenialReason
MC	R	36	MC125	Attending Provider	HashAttendingProvider

Release File Column Names: Restricted Release Elements					
FILE	**P/R**	**Element Order**	**Element**	**Data Element Name**	**Release File Column Name**
MC	R	37	MC134	Plan Rendering Provider Identifier	HashPlanRenderingProviderIdentifier
MC	R	38	MC135	Provider Location	HashProviderLocation
MC	R	39	MC137	CarrierSpecificUniqueMemberID	HashCarrierSpecificUniqueMemberID
MC	R	41	MC141	CarrierSpecificUniqueSubscriberID	HashCarrierSpecificUniqueSubscriberID
MC	R	42	MC001 / MC080	Payer / Reason for Adjustment	HashPayerReasonforAdjustment
MC	R	43	MC001 / MC124	Payer / Denial Reason	HashPayerDenialReason
MC	R	44	Derived by DHCFP	Unique Record ID	PublicUseID
DC	R	1	DC001	Payer	HashPayer
DC	R	2	DC002	National Plan ID	HashNationalPlanID
DC	R	3	DC003	Dental Insurance Type Code/Product	HashDentalInsuranceTypeCodeProduct
DC	R	4	DC004	Payer Claim Control Number	HashPayerClaimControlNumber
DC	R	5	DC006	Insured Group or Policy Number	HashInsuredGrouporPolicyNumber
DC	R	6	DC011	Individual Relationship Code	IndividualRelationshipCode
DC	R	7	DC013	Member Birth Month	MemberDateofBirthMonth
DC	R	8	DC014	Member City Name	MemberCityName
DC	R	9	DC016	Member ZIP code (first 3 digits)	MemberZIpCodeFirst3Digits
DC	R	10	DC017	Date Service Approved (AP Date)	DateServiceApprovedAPDate
DC	R	11	DC018	Service Provider Number	HashServiceProviderNumber
DC	R	12	DC019	Service Provider Tax ID Number	HashServiceProviderTaxIDNumber
DC	R	13	DC025	Delegated Benefit Administrator Organization ID	HashDelegatedBenefitAdministratorOrganizationID
DC	R	14	DC035	Date of Service - From	DateofServiceFrom
DC	R	15	DC036	Date of Service - Thru	DateofServiceThru
DC	R	16	DC042	Product ID Number	HashProductIDNumber
DC	R	17	DC044	Billing Provider Tax ID Number	HashBillingProviderTaxIDNumber
DC	R	18	DC046	Allowed Amount	AllowedAmount

Release File Column Names: Restricted Release Elements					
FILE	**P/R**	**Element Order**	**Element**	**Data Element Name**	**Release File Column Name**
DC	R	19	DC056	CarrierSpecificUniqueMemberID	HashCarrierSpecificUniqueMemberID
DC	R	20	DC057	CarrierSpecificUniqueSubscriberID	HashCarrierSpecificUniqueSubscriberID
DC	R	22	Derived by DHCFP	Unique Record ID	PublicUseID
PC	R	1	PC001	Payer	HashPayer
PC	R	2	PC002	Plan ID	HashPlanID
PC	R	3	PC003	Insurance Type Code/Product	HashInsuranceTypeCodeProduct
PC	R	4	PC004	Payer Claim Control Number	HashPayerClaimControlNumber
PC	R	5	PC006	Insured Group or Policy Number	HashInsuredGrouporPolicyNumber
PC	R	6	PC011	Individual Relationship Code	IndividualRelationshipCode
PC	R	7	PC013	Member Birth Month	MemberDateofBirthMonth
PC	R	8	PC014	Member City Name of Residence	MemberCityNameofResidence
PC	R	9	PC016	Member ZIP code (first 3 digits)	MemberZIpCodeFirst3Digits
PC	R	10	PC017	Date Service Approved (AP Date)	DateServiceApprovedAPDate
PC	R	11	PC018	Pharmacy Number	HashPharmacyNumber
PC	R	12	PC019	Pharmacy Tax ID Number	HashPharmacyTaxIDNumber
PC	R	13	PC032	Date Prescription Filled	DatePrescriptionFilled
PC	R	14	PC032	Date Prescription Filled Month	DatePrescriptionFilledMonth
PC	R	15	PC032	Date Prescription Filled Year	DatePrescriptionFilledYear
PC	R	16	PC043	Prescribing ProviderID	HashPrescribingProviderID
PC	R	17	PC047	Prescribing Physician DEA Number	HashPrescribingPhysicianDEANumber
PC	R	18	PC051	Prescribing Physician Street Address	PrescribingPhysicianStreetAddress
PC	R	19	PC052	Prescribing Physician Street Address 2	PrescribingPhysicianStreetAddress2
PC	R	20	PC056	Product ID Number	HashProductIDNumber
PC	R	21	PC058	Script number	ScriptNumber
PC	R	22	PC059	Recipient PCP ID	HashRecipientPCPID

Release File Column Names: Restricted Release Elements					
FILE	**P/R**	**Element Order**	**Element**	**Data Element Name**	**Release File Column Name**
PC	R	23	PC062	Billing Provider Tax ID Number	HashBillingProviderTaxIDNumber
PC	R	24	PC064	Date Prescription Written	DatePrescriptionWritten
PC	R	25	PC064	Date Prescription Written Month	DatePrescriptionWrittenMonth
PC	R	26	PC064	Date Prescription Written Year	DatePrescriptionWrittenYear
PC	R	27	PC068	Allowed amount	AllowedAmount
PC	R	28	PC072	Delegated Benefit Administrator Organization ID	HashDelegatedBenefitAdministratorOrganizationID
PC	R	29	PC107	CarrierSpecificUniqueMemberID	HashCarrierSpecificUniqueMemberID
PC	R	30	PC108	CarrierSpecificUniqueSubscriberID	HashCarrierSpecificUniqueSubscriberID
PC	R	32	Derived by DHCFP	Unique Record ID	PublicUseID
PV	R	1	PV001	Payer	HashPayer
PV	R	2	PV002	Plan Provider ID	HashPlanProviderID
PV	R	3	PV003	Tax Id	HashTaxId
PV	R	4	PV005	DEA ID	HashDEAId
PV	R	5	PV007	Medicaid Id	HashMedicaidId
PV	R	6	PV015	Provider DOB Year	DOBDateYear
PV	R	7	PV016	Street Address1 Name	StreetAddress1Name
PV	R	8	PV017	Street Address2 Name	StreetAddress2Name
PV	R	9	PV035	SSN Id	HashSSNId
PV	R	10	PV036	Medicare Id	HashMedicareId
PV	R	11	PV054	Medical/Healthcare Home ID	HashMedicalHealthcareHomeID
PV	R	12	PV056	Provider Affiliation	HashProviderAffiliation
PV	R	13	Derived by DHCFP	Unique Record ID	PublicUseID

Appendix 4: Versions of This Document

7/20/12	Draft for Review Version 2	• Revisions to document as per review by Kathy Hines, Paul Smith, and Adam Tapply. • Revisions to File Layout section Release Notes column as per input from Marc Prettenhofer. • Revisions to File Layout Description column to mark lookup tables and outside code sources. • Revisions to File Layout section Data Type Guide and Field Length columns as per Taddele Firew's information from the Release Warehouse. • Glossary of Terms section added, with a few items marked for review by team.
8/1/12	Draft for Review Version 3	• Editing of Release Notes, Descriptions, Lookup Tables • Addition of APCD Threshold column • Merged Edit Level A columns
8/9/12	Draft for Review Version 3.6	• Editing for responses to HHines 7/31 issues list • Editing for KHines review of sections including Glossary reviewed items • 8/3 proposed changes to field lengths and release status • Datetime field length changed to 23 • HHines editing of Introduction, Lookups, Data Protection, Linkage sections.
8/14/12	Draft for Review Version 3.7	• Revised some max lengths on checking spreadsheet and document against Isabel's new master file (data types: int and money)
8/15/12	Draft for Review Version 3.8	• Removed Filler fields from 'Not Released' file layout sections; re-numbered the Rel Col column.
9/18/12	Draft for Review Version 4	• Various changes made after document review by KHines, and testing of release files.
9/18/12	Draft for Review Version 4.1	• Added Edit Information for Grouping table
9/28/12	Draft for Review Versions 4.2, 4.3	• Various changes requested by KHines • Added Appendix: Release File Column Names • Changed description, type and length for Final Version Flag
10/29/12	Final Version 1.0	• Add HDAG Team edits; Insert updated Variance Statistics table.